

ARCHIVES OF SURGERY.

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ON SIMULATIONS OF SYPHILIS.

THAT syphilis, in its various developments, may very closely simulate other maladies has long been matter of comment. Thus we have a syphilitic form, or imitation, of almost every kind of skin disease that can be mentioned. The closeness of its resemblance to common lupus, to psoriasis, and even to small-pox, is often very deceptive. I purpose now to ask attention to cases of an opposite kind, in which several, or even many, of what are supposed to be characteristic phenomena of syphilis are grouped together, and yet there remains much doubt as to whether the disease really is of that nature. We are so much accustomed to consider that a sore throat and a dusky, or coppery, eruption on the skin are, when met with together, indications of syphilis, that we often venture to disregard the absence of history, and to hold that they, in themselves, constitute the diagnosis. If with them, or with either of them, there goes the evidence of periosteal inflammation, we trust our conclusion yet more implicitly, and the subsidence of the symptoms under mercury or iodides is usually held to extinguish all doubt. In nine cases out of ten, perhaps in nineteen out of twenty, our confidence in our conclusions is not misplaced. I may confess, however, to a suspicion that cases do occur in which it is possible for the most careful observers to make mistakes, or to be left in doubt. In approaching the discussion of such,

we must rid our minds as far as possible of prejudice (prejudicium), and avoid excess of self-confidence. After all, the phenomena of syphilis are only those of a specific animal poison acting through the blood. It is quite possible that other animal poisons may exist capable of evoking very similar results. Small-pox is attended by an eruption, and is sometimes followed by periostitis and necrosis. So of the other specific fevers.

Dr. Creighton has broached a theory that true cow-pox and syphilis are really related, because in certain cases, after vaccination, symptoms resembling those of syphilis occur. But it does not follow from this fact that there is any more close relationship between these two diseases than there is amongst all the specific fevers. It is very possibly only a question of resemblance. I believe that I have myself supplied, with regret, to those who hold Dr. Creighton's views some of their best facts. I say with regret, because I cannot support his theory, and fear that it may prove mischievous.

The cases to which I refer in the last paragraph are those recorded in former volumes of ARCHIVES, in which, after vaccination, the arm was attacked by sloughing and there followed an eruption and periostitis. The Leeds case (see ARCHIVES, Vol. I., p. 106) is one of these. No doubt was entertained by some of the surgeons to the Leeds Infirmary that this infant had syphilis, and that it had been conveyed by vaccination. In another case (see page 98), exactly the same train of phenomena occurred, and the surgeon who principally had charge of the patient, and who saw the eruption, felt, like the Leeds surgeons, quite sure that the disease was syphilis. In this instance, however, the lymph used was from the calf, and the most careful examination failed to elicit any possible contamination. I do not myself believe that either of these cases was really syphilis, but incline to the opinion that the results of vaccinia simulated syphilis. In a third case (ARCHIVES, Vol. II., p. 213) a child vaccinated from the calf had sloughing sores, an eruption, and nodes on the skull of the most definite kind. This child recovered, and is now in excellent health. Nothing whatever has occurred to support the suspicion of syphilis excepting that the recovery took

place under specifics. The latter were used, however, for only a short time, and there has been no relapse since they were laid aside. I do not think that this case was one of syphilis, but rather of its simulation by another animal poison, to wit, vaccinia. I wish to avoid dogmatism in this matter, and to admit fully that the cases are open to much doubt. They seem, however, as a group, to give mutual support to the incredulity as to syphilis which I have expressed.

That mercury and iodides may appear to act as specifics in maladies which are not syphilitic, ought, I think, to be freely admitted. They probably cure syphilis simply by restraining the vital activity of a zymotic parasite, and they may have the same power in reference to others of the class. There are many facts which support the belief that they have. It is only by a sort of accident that we have come to regard them as specific against syphilis only. In particular, iodide of potassium will cure any form of periosteal inflammation.

I would instance the phenomena of Yaws as an instance of the simulation of syphilis of the most instructive kind, were it not that there seems to be much reason for suspecting that, after all, it is syphilis. Those familiar with the literature of this malady will know that the question has been much debated, and that almost without an exception observers who have had personal experience affirm that Yaws is not syphilis. Yet it is a disease which begins by a local sore, the result of contagion, has a general eruption which comes two or three months after the sore and which has various stages; it has tertiary symptoms of which bone disease is one of the chief, and in all its stages mercury and the iodides are the only efficient remedies.* If it be not simply "negro syphilis," it is indeed a most close simulation.

When one observer has seen the eruption and another has not, it may seem almost an impertinence in the latter if he presumes to doubt the assurance that it was "characteristically syphilitic." My position, however, in reference to this question, is that I scarcely know of any eruption the features of which are in themselves sufficient for a diagnosis. I have

* See an Essay by Dr. Numa Rat, of Dominica, to which I have contributed a Preface in which these points are discussed in some detail.

seen so many concerning which I have had to note that they were exactly like syphilitic ones which I yet did not diagnose as such, that I cannot feel convinced by the testimony of any one else, however skilled or however confident. Conviction to my mind can come only from the whole history and course of the disease, and not from any one, or even two, of its phenomena, however apparently well marked.

I shall reserve for another paper the description of certain cases in which eruptions occurring under doubtful circumstances were exactly those of syphilis, whilst yet probably not such. For the present I propose to narrate only a single case in which all the phenomena were those of specific poisoning, and most of them like those of syphilis, and in which still there were very noteworthy elements of doubt. The case is one of the most puzzling that I have seen for some years.

I saw the case to which I refer at Maidstone, in consultation with Dr. Ground. The consultation was on December 20th, 1888. The patient sank (as we expected) about a month later, and Dr. Ground's zeal was successful in obtaining an autopsy, so that I am in a position, in some sense, to complete the case. Its subject was a young gentleman of about twenty, serving on one of her Majesty's ships then stationed in the Medway. There was no reason to think that he had ever exposed himself to the risk of contracting syphilis, but as he was mixing, on board ship, with many other young men, and had to use the same lavatories, &c., there was possibility of accidental inoculation. He had enjoyed excellent health until the present illness, which had begun in the beginning of September with loss of strength and swellings on the head. He came home from his ship to visit his parents, and they thought him looking ill. On September 29th he was for the first time seen at his home by Dr. Ground, and from this date he remained at his home as an invalid. Dr. Ground discovered a number of periosteal swellings on the head, which it was impossible to distinguish from ordinary nodes, and for which he at once prescribed iodide of potassium. At this time there was also paralysis of the left facial and sixth nerves, but it was only temporary. The nodes were not painful. Two or three weeks later, the lad was covered

with a papular eruption, which both Dr. Ground and his partner, Mr. Hoare, carefully inspected and considered to be characteristically syphilitic. On the appearance of the eruption, the use of mercury was commenced, and it was pushed to slight ptyalism. The treatment at first appeared to be very satisfactory, for the eruption faded away and the periosteal swellings disappeared, the patient's health at the same time improving. Rather suddenly, however, in the beginning of December, a great increase in debility occurred with very marked emaciation. There was also most troublesome vomiting. This latter was eventually relieved by the application of cocaine to the throat. It should be said that throughout the case one of the marked symptoms had been a remarkable tendency to dryness of the mouth. A careful search had of course been made for a primary sore, but none had been found. The tonsils had in the first instance been very much swollen, so that they "almost met across the pharynx," and at this time there was also great swelling of the glands of the neck.

When our consultation took place (it was about three months from the commencement of the illness) the tonsils had almost wholly subsided, the papular eruption had quite disappeared, and there remained but slight evidences of the periosteal swellings on the skull. The skin of the body, however, was not clear; it presented large, ill-defined, darkish stains, which made me think of the possibility of Addison's disease. Our patient was confined to his bed, much emaciated and very weak. His mouth was very dry. He had been a fortnight without mercury, and had been fed by enemata and peptonized food. His abdomen was tumid, and we entertained the suspicion that he might have some malignant tumour in it, but none could be felt definitely. The evidence in favour of syphilis—the nodes, the rash, the enlarged tonsils, and the disappearance of all three on specific treatment—seemed to be strong. Yet the order of development of the symptoms had been very exceptional, and we had to remember that no chancre had been discovered. Having regard to his state of extreme debility, which was rapidly increasing, we were obliged to give a very unfavourable

prognosis, and did not venture to recommend for the present any return to specific treatment.

About a month after my visit, death from exhaustion took place. There had been, meanwhile, an increase of lung symptoms, but nothing bearing upon the diagnosis of syphilis.

The autopsy showed extensive suppuration and gangrenous pneumonia in both lungs. No gummata and no tubercle. The abscess cavities contained foetid pus. Spleen enlarged and soft. Kidneys much enlarged and showing characteristic appearances of advanced amyloid degeneration. Supra-renals enlarged and indurated, and the cellular tissue about them condensed. Nothing of importance was found in the head.

In the hope of facilitating the reader's appreciation of the facts, I will state them in the space-for-time method. (See next page.)

Comments.

I wish to treat with the utmost respect the opinion still entertained, I believe, by Mr. Hoare and Dr. Ground (who saw the case throughout), that the disease was really syphilis, and I feel sure that they will in turn pardon some incredulity on my part. The following are amongst my reasons for doubt :—

Nodes were the first symptom, and for some time the only one.

The swelling of the tonsils and cervical glands was much in excess of what is usual in syphilis.

The eruption may have been modified by the iodide which had been given.

There were no indications of syphilis when I saw the patient.

In spite of apparent benefit from specifics, the case ended fatally (as did also two of the vaccination cases).

There was nothing in the cause of death indicative of syphilis.

There had never been any chancre.

A young midshipman became affected by periosteal swellings on the skull—Great enlargement of tonsils and cervical glands—No chancre to be found, and no history of any infection—Subsequent general eruption over body—Apparent cure of all symptoms by mercury—Great failure of strength with sickness—Death in fifth month with double gangrenous pneumonia.

AGE.	DATE.	DETAILS.
22	September	Noticed some hard lumps on head; quite painless. Felt choked in throat, no pain, but some difficulty in swallowing. Swelling of tonsils and of cervical glands very great, and symmetrical. Came home ill September 29th, and first seen by Dr. Ground.
	October	The swellings on skull from size of pea to a cob-nut. Left side of face felt stiff and left limbs a little numb; slight facial paralysis (left), and left pupil dilated and motionless; pain along both sciatics. October 14th, a dusky mottling, followed a week later by a papular eruption. He was taking mercury and iodides before the rash came out. Pulse 120. Temperature normal.
	November	The gums had been made a little tender by inunction of mercury, and all the external symptoms had disappeared by the 20th. He was still much troubled with sickness. The urine contained neither albumen nor sugar. At this time he seemed much better, and the pulse was only 100.
	December	He began rapidly to lose ground, becoming very weak, pale, and emaciated. Some brown stains on skin and purplish ones on lips suggested Addison's disease. 19th, <i>I saw him with Dr. Ground at his home at Maidstone.</i> Tonsils not enlarged, and no signs of former disease. No nodes and no eruption remaining. A certain amount of bronzing. Very weak. Dry mouth; unable to take food. Evidently going to die.
	January	21st, Death from gangrenous pneumonia.

Autopsy.—No gummata found. Double gangrenous pneumonia with fœtid abscesses. Enlarged kidneys, amyloid. Spleen large and soft.

ON ECZEMA-CANCER.

THE creed that cancerous action is for the most part a modification of chronic inflammation, and that it is frequently, indeed usually, introduced by disturbances of cell nutrition which have nothing of a malignant character, has been repeatedly upheld in ARCHIVES. It has also been further suggested that most cancers take their peculiarities from the tissue in which they originate, and the kind of inflammatory disturbance which has preceded them. With these principles in view there will seem nothing strange in the suggestion that a clinical group of malignant ulcerations of the skin may conveniently be known as Eczema-Cancer. It would comprise all forms of cancer of the skin preceded by conditions indistinguishable from common eczema; cases, in fact, in which cancer supervenes on eczema. Such cases display peculiarities throughout their whole course, being remarkably prone to spread superficially, and very slowly, and to permit of cicatrization on the parts which have been abandoned. They but rarely are attended by gland implication. Thus it will be seen that the cancer, although quite incurable by the remedies for eczema, keeps to the end certain features which disclose its parentage. So close indeed, in some instances may be the resemblance, that difficulties may arise as to whether the malady should be diagnosed as eczema or cancer. I have already proposed the term Eczema-Lupus for certain other rare cases in which an exceedingly superficial form of Lupus engrafts itself on eczema patches, and keeps throughout certain features of similarity. I feel sure that these composite names are not only very convenient in practice, conveying as they do a clear suggestion of the nature and aspect of the malady, but that they are based upon sound pathological doctrines. In the same

way we have "Lupus-Cancer"—a name very appropriate to the now well-recognized group of cases in which epithelial cancer supervenes upon lupus, and runs, in virtue of the peculiarity of its origin, a peculiar course.

The group of Eczema-Cancer will include many cases of rodent ulcer on the face, for such are often preceded by patches of dry eczema and attended by the presence of such on other parts. It will include also the disease of the skin of the female breast now known as Paget's nipple; also the malignant growths which occur in Kaposi's disease, and some of those which have counted as granuloma fungoides. It will include also certain other much more rare cases in which malignant ulceration occurs in regions liable to be affected by eczema marginatum (the crutch), and in which it is apparently engrafted on that malady. Of this occurrence I have seen several examples.

A Case of Eczema—Cancer of the Scrotum and Thigh.

Dr. Radcliffe Crocker has recorded in the Transactions of the Pathological Society an important example of a superficial form of malignant disease of the skin of the scrotum. The narrative is accompanied by a portrait and full details as to histology. The peculiar feature of the disease was that for the most part only the superficial layers of the skin were affected, no tendency to deep ulceration being present. Dr. Crocker very plausibly compares it with Paget's eczema-cancer of the nipple, but admits that in most features it was indistinguishable from a superficial rodent cancer. The difference is perhaps mainly one of words. The microscope left the question undecided with which the form of malignant growth should rank.

I have had under occasional observation for more than two years a case very similar to Dr. Crocker's. In the first instance I saw the patient, a gentleman of about sixty, with Mr. Marrant Baker, who gave me the particulars of treatment, &c., during two preceding years, and much assisted in the diagnosis. In this case superficial ulceration has spread very widely over one side of the scrotum and the adjacent parts of the thigh and perineum. The area involved is as

large as two outspread hands. Imperfect cicatrisation has taken place over a large part of the surface, but the edge is still advancing. The edge is very slightly raised, and at parts presents the smooth roll which characterizes rodent, and at others is slightly papillary. Although the disease has been present at least ten years, there has been no gland disease.

We have derived much benefit from painting the edge from time to time with strong carbolic acid.

It will be seen that these two cases differ most definitely from chimney-sweep's cancer and ordinary epithelioma, not only in remaining superficial, but especially in the fact that there has been no tendency to gland disease. In both these features they fit well with the form of epidermic cancer which we know as rodent ulcer. This latter, however, although sometimes remaining superficial, often eats deeply. No one looking at Dr. Crocker's portrait can fail to be struck with the resemblance of the edge to that of rodent.

In Dr. Crocker's case the ulceration was confined to the penis and scrotum. In mine it began in the crutch, just the part where eczema is common, and spread on each side. In mine the disease is far too extensive to permit of excision, a measure which was successful in Dr. Crocker's patient.

I find recorded by Mr. Henry Morris in the Medico-Chirurgical Transactions a case which may be fairly claimed as an example of eczema-cancer. A woman of 55 had "a red and scaly patch on the right side of her neck, which remained much in the same condition for five years, shedding fine light scales." At the age of 60 it took on a malignant character (epitheliomatous). It developed superficially to the size of a man's hand, and also in its centre passed deeply. The patient had long intervals of health after Mr. Morris's extensive operations, and was alive and well four years after the first. It would appear that the glands were not implicated.

Sun-eczema of face and hands—Malignant fungating growth on one cheek and ulceration of lip—Granuloma fungoides.

A very remarkable example of malignant disease superven-

ing upon eczematous irritation consequent on sunburn is at present under my observation. A Portuguese gentleman, aged 42, came over from Brazil to be treated for a large fungating growth in the middle of his left cheek. The mass was as large as a child's fist, and was covered with a thick crust, in the detachment of which bleeding was easily caused. A remarkable feature of an otherwise very formidable-looking condition of things was that the cheek itself was not deeply infiltrated. On passing the finger into the cheek-pouch it was ascertained that the growth did not involve any material thickening of the parts beneath, and was quite superficial. My patient had been told before he left home that his disease was malignant, and had come over for operation. In addition to the cheek-growth he had an ulceration of the prolabium of his lower lip near the left angle of his mouth, which presented very suspicious symptoms. The important feature in his case, however, in reference to theory of cause was the presence in various parts of his face, neck, and backs of hands of superficial eczematous abrasions and patches covered with crust. These he asserted without hesitation were due to sun-exposure. He had lived in a very hot climate, and the sun had, he said, often blistered him. Although a Portuguese he was not of dark complexion, but had red hair and brown eyes. In this probably was the explanation of his susceptibility to the sun. The liability to sun-eczema had commenced about nine years ago in a definite manner, though there had been some degree of susceptibility for much longer. It had affected only the exposed surfaces. The backs of his hands were covered all over with thin scars and dry epidermic crusts, but were not at the present time in the least inflamed. I have called the condition eczema, and such, I believe, in the first instance it had been. But at the time that I saw the case the conditions were somewhat modified. A specialist friend whom the patient had consulted before he came to me, suggested the diagnosis of granuloma fungoides. The sores which were present on his face and neck presented the condition of very superficial abrasions covered very loosely by pus crusts. I found subsequently, under treatment, that though most of them healed very readily, some of them did not. In

a portrait that was taken for me by Mr. Burgess, the conditions which I have described have been somewhat exaggerated.

I operated upon the cheek and lip in the early part of May, 1892. With a pair of strong scissors I cut away the fungating growth, and having next well scraped the surface, lastly used the actual cautery very freely. The result was a very large sore, but in the course of about a month it had healed soundly. The lip, which had been treated in a similar manner, also healed well. At the end of a month the whole of the patient's face was quite free from crusts, but there still remained one or two little unhealed ulcers on his neck. These ulcers looked exactly like crusted eczema, but were difficult to cure unless freely cauterized. He complained of one of them that it was very sore, although it looked insignificant.

My son made a careful microscopic examination of the parts removed from the cheek, and I append his report: "Sections of the large fungating growth showed it to be singularly friable and soft, with a somewhat lobulated arrangement. It was composed of masses of epithelial structure, with a fair number of cell-nests. The boundary between these epithelial ingrowths and the corium was generally well defined. The growth is undoubtedly a soft form of epithelioma."

Postscript.

Since the above notes were in type, I have had to use the cautery again to destroy a small fungating growth in the recently healed scar.

ON CROUP AND ITS TREATMENT.

THERE are many questions in reference to croup upon which professional opinion has undergone strange vicissitudes. Some of these concern the nature of the disease, some its treatment by operation, and others the usefulness or otherwise of different drugs. As regards tracheotomy, it might seem that the victory has at last been won, and that, unless displaced by intubation, it is now well established as a legitimate and fairly successful measure in cases of advanced croup. It has taken somewhat more than half a century to attain this position, and (as also in the instance of ovariotomy) it is exceedingly difficult for the historian of surgical progress to trace the various steps by which an operation which was formerly successful in only a small minority of cases has now turned the tables, and is—at any rate in the hands of some surgeons—fatal only in the proportion of its former success.

It may be of interest to cite a few clinical illustrations of the methods of treatment employed by our predecessors.

We may note in the following case that tracheotomy does not appear to have been even thought of, although the patient was seen by a most distinguished surgeon. It is from Sir Astley Cooper's Note Books, and was published after his death.

“The daughter of Mr. —, in Goodman's Fields, was seized, at the age of fourteen months, with a hoarseness, which continued for three days without its otherwise affecting her health. At the end of this time she began to cough, and that with so peculiar a noise as to characterize the disease.

“A leech was applied to the throat, which sucked about six ounces. Calomel was given, and two blisters were applied.

to the throat. Notwithstanding this treatment, great difficulty of breathing, with frequent coughing, succeeded, and after some hours she died—not absolutely suffocated, but from irritation and difficult breathing united. *Dissection.*—The larynx was the only part permitted to be examined, which was very highly inflamed; the glottis was much narrowed by an effusion into the cellular membrane there. There was no effusion of lymph in this part.”

I take the last expression to mean that there was no false membrane. Thus we have probably a good example in a child of fatal laryngitis of the same type as that common in the catarrhal disease of the adult, attended by swelling and oedema, but without false membrane.*

That cases of this type of catarrhal laryngitis may sometimes recover without tracheotomy, even after the most urgent conditions have been developed, is proved by the following. I quote from a detailed report of the case by the late Sir Arnold J. Knight, of Sheffield, under date Oct. 1841. The child, a boy of four, was first seen by Sir A. J. Knight on Sunday, Oct. 10, the fourth day of his croup. He had been previously under other treatment, with the diagnosis of “croup” from the beginning. “The little patient’s countenance was now pale, the lips livid; pulse quick; breathing and cough of that kind peculiar to the advanced stage of croup.” A mustard plaster was ordered, and the feet were put in hot water. Calomel in five-grain doses was ordered every hour until it should purge. In the evening four of the powders had been taken without effect, and they were substituted by a teaspoonful of ipecacuanha wine every quarter of an hour, and a blister was applied between the shoulders. The ipecacuanha soon caused vomiting, and the child seemed a little relieved. On Monday evening, however, “the child appeared to me so nearly suffocated, that though I had given his friends little hope from the first, I now told them he could not survive the night. I repeated, however, the ipecacuanha wine, and ordered two more calomel powders as before.” During the night the child appears to have nearly

* For some remarks on the different forms of laryngitis to which the terms croup and diphtheria have been applied, see Catechism, p. 90 of present volume.

died; in the morning, however, a change took place for the better, and he rather rapidly improved. After this there was no relapse, and he "was soon restored to his former state of good health."

There is no mention of the expectoration of any croupous membranes, and probably none were seen. No one can doubt, however, that the case was one of inflammatory croup, not spasm, and that it was attended, if not by false membranes, by great swelling of the mucous membrane. It was one in which, undoubtedly, no surgeon of the present day would have omitted to open the trachea. The narrative, is I think, of much value as illustrating the vigorous practice of the past generation, and both from its negative and positive sides. It proves that, even from the most apparently hopeless conditions, children may recover, and that, too, notwithstanding the use of mercury in doses which we in the present day should consider dangerous. The use of the ipecacuanha wine as an emetic was probably judicious, combining as it did the sustaining influence of sherry wine with the advantages of vomiting. It is only in the early stage of laryngitis that tartar emetic is preferable to ipecacuanha.

At the time that Sir A. Knight was treating croup in Yorkshire in full reliance upon drugs, and—following Sir Astley Cooper's leading—without apparently a thought of operative interference, tracheotomy was securing a fair trial in the Paris hospitals. If, however, the results of such trial had become known in Sheffield, they would certainly not have done much to induce hope from a change of practice.

In the *Bullet. de Therap.* for Jan., 1842, Dr. Becquerel recorded, with praiseworthy candour, the results obtained in the treatment of croup at the Children's Hospital in Paris during the previous year. During 1841, twenty cases diagnosed as true croup had been admitted, and all the patients had died. One of them had survived two months, and had died not of croup, but of pulmonary tuberculosis; but all the other nineteen had perished directly from the results of croup. Tracheotomy had been performed in nine, and it had not saved a single one. In all, the operations

had been executed quickly and without difficulty, and in none was it believed that any injurious quantity of blood had entered the trachea. In one case it had been done on the second day, in three on the third, in three on the fourth, in one on the fifth, and in one on the sixth. In several cases the whole of the false membrane was removed at the time of operation, and did not form again. In one case not a trace of false membrane was found either at the time of operation or at the autopsy, although the usual symptoms of croup had been well marked. In this case M. Guersant (*fils*) was the operator. In most cases great apparent relief had resulted immediately after the operation. Amongst the causes of death were bronchitis, pneumonia, persistence of the original disease, and convulsions. In several the patient sank without there being any local condition discoverable to explain the fatal event. In two of the nine tracheotomy cases, the operation was done *in extremis*, and the patient died soon after its conclusion. Of the others, in one the child survived 7 hours, in one 10 hours, in one 29 hours, in one 30 hours, in one 42 hours, in one 7 days, and in one 10 days. In this last case the edges of the wound took on phagedæna.

This report of Dr. Becquerel's was written nearly twenty years after the very able article on croup by M. Guersant, *père*, in the "Dictionnaire de Médecine" (1823). In this article the question of tracheotomy was considered in detail, and M. Guersant was compelled to admit that he knew of no single instance of recovery, although he spoke evidently from a very considerable experience. He even thought it worth while to devote some space to a reputed success which had occurred in London, and to cite evidence that the operation was for the removal of a foreign body and not for croup. We may take it, then, as certain that at this date no single instance of recovery after tracheotomy for croup was known to the Paris surgeons.

It is a great mistake—though a very common one—on the part of nosologists to take the degree of severity of the case as an element in its limitary definition. In this way mild cases of catarrhal croup have been classed as "pseudo-croup," and no cases have been permitted to receive the designation of "true

croup" excepting those which went the length of having an abundant false membrane, and put the patient's life in great danger. Thus M. Guersant writes that he has never seen pseudo-croup prove fatal, and that thus he is ignorant of its pathological anatomy. He holds that it is far more common than true croup. The fallacy is obvious, that had the case been severe, and threatened to be fatal, he would have classed it at once as true croup. It is probable that hundreds of children suffer from slight forms of catarrhal pharyngo-laryngitis, for one who passes into the more characteristic stage of membranous croup. The tendency to the free formation of membrane is probably a matter of individual proclivity (an idiosyncrasy), whilst the catarrhal origin of the disease and its nature in the commencement of the attack is the same in all.

It is not a little difficult to explain why the French surgeons were not more successful with this operation; for M. Guersant appears to have been well aware of the importance of removing all false membrane; a measure which some have erroneously supposed to be a modern improvement. He speaks of special forceps designed for this purpose by M. Dupuytren, and also of the use by M. Magendie of a feather introduced repeatedly with reversed barbs.

M. Guersant speaks strongly of the usefulness of mercury. Calomel is the preparation which he preferred, in doses of from half a grain to two grains every two hours. He remarks that although it is seldom in children attended by the inconvenience of salivation, yet that there is no object in giving it in the enormous doses which some have recommended, "as, for instance, one to two hundred grains a day." He also speaks highly of ipecacuanha.

The above statements, although fragmentary, may suffice to give us a vivid picture of the practice of surgeons in the first half of the century in reference to the treatment of diphtheria and croup. What I have to add, although not less fragmentary, may, I trust, serve to place that of more recent times in an equally clear light.

Although my own practice has been to perform tracheotomy whenever indicated, I may confess at once that I have had but very little success. During the twenty-five years that I

was on the active staff of the London Hospital I do not think that I did the operation with my own hands more than two or three times. It was considered to be a house surgeon's operation, and unless the surgeon chanced to be in the house he was not sent for. I do not remember more than two or three recoveries in all. Cases of croup or diphtheria were, however, of rare occurrence, and the total of tracheotomies was not large. In private I did considerably more, but with very discouraging results. The last patient but one for whom I have been consulted who needed the operation I transferred to the care of my friend and former house surgeon, Mr. Robert W. Parker, knowing the interest which he took in the subject. In his hands the little patient made a good recovery. Another case of recovery in which I operated myself is worthy of mention, because it throws much light upon the constitutional origin of membranous croup. I was summoned by telegraph a considerable distance into the country for the express purpose of performing the operation. My carriage was at the door when the telegram was put into my hand, and at Charing Cross a train was just starting when I got there. These favouring circumstances enabled me to get to my patient just in time. Tracheotomy was done under most urgent circumstances, much membrane was removed, and the child did well. It was, I was told, the third or fourth time that this child had been threatened with croup, and since its recovery I have heard that it has had another alarming threatening. Thus the case may be held to prove that a child liable to catarrhal laryngitis may have one of its attacks more than usually severe and attended by the free formation of membranes.

In conversation a few weeks ago with a very distinguished surgeon and professor of surgery, he told me that he regarded tracheotomy in diphtheria as simply a means of alleviating the agonies of death. Concerning croup he was more hopeful, but he agreed with me that it was often quite impossible to distinguish between the two.

During a visit to the hospitals of Copenhagen, about ten years ago, I was told that diphtheria and croup were very common, and that special preparations for prompt trache-

otomy were kept in constant readiness. At one hospital a large proportion of the cases recovered, and at another almost all died. My informant said that he could not explain the difference. It is one which, unless my sources of information much mislead, exists at the present time between different hospitals in London.

I have before me a volume of Selections from the Statistics of St. Thomas's Hospital, and also the last two volumes of St. Bartholomew's Hospital Reports. Without in the least professing to collate statistics, I will take from these volumes a few statements of fact which bear with much interest upon my subject. The records of cases at both these hospitals are, as is well known, admirably kept.

I will take first St. Thomas's Hospital. In the records for the year 1869 I can find no mention of croup, diphtheria, laryngotomy or tracheotomy. In 1870 one case of diphtheria is mentioned. It was in an adult, and recovered without an operation. In 1871 there was one case of diphtheria; in an adult, and fatal, without operation. On the surgical side there was one of croup in a child under five, fatal in a few hours after tracheotomy. In 1872 there was a single case of tracheotomy for croup in a young child. It was fatal. In 1873 two cases of diphtheria are recorded, and both ended fatally. In one the diagnosis was doubtful, and no operation was demanded. In the other, a child of nearly two had tracheotomy performed immediately on admission, and died a few hours afterwards. The post mortem showed "the larynx and trachea filled with false membrane." A third case of diphtheria originated in the hospital, and ended in death. In 1874 the medical registrar reports five cases of diphtheria, three of which had originated in the hospital (in nurses). These three were not severe, and all resulted in recovery. One case, which ended in death, is worthy of being quoted in full, since it conveys an important lesson as to the mode of development of the disease. It also discloses the fact that at that time insufficient attention was given to the removal of false membranes.

"A child, æt. 3, was admitted on May 10th, having had what was supposed to be a severe cold for three days before; she was seized on the day before

admission with sore throat and severe croupy cough; the respiration rapidly became embarrassed, and when admitted she was livid and apparently moribund. Tracheotomy was immediately performed, with great relief, and the patient slept well, and took food; but on the following day the respiration again became embarrassed, and death occurred about thirty hours after the operation. *Post mortem*:—Exudation was found in the upper part of the pharynx and the posterior nares, and the whole larynx and trachea were completely plugged by a quantity of exudation, forming a solid cast of the tube. The larger bronchi were also filled by exudation and the lungs partially collapsed.”

The surgical report for this same year (1874) records five cases of diphtheria, all fatal, and one of croup, also fatal. All six patients were under five years of age. In all, tracheotomy had been done on the day of admission.

In 1875 the medical report gives seven cases of diphtheria, all recovering, and two of croup, both fatal. The surgical report gives two of croup (probably the same two) and one of diphtheria, all submitted to tracheotomy and all fatal.

From 1875 I take a leap to 1883.* In this year the medical report records 32 cases of diphtheria with 16 deaths, whilst the surgical report does not mention croup, diphtheria, or tracheotomy. It would appear that the faith of the physicians in the benefits of operation had sunk so low that, although the disease was prevalent and fatal in no less than 50 per cent., they found no cases in which it seemed worth while to invoke the surgeon's aid.†

I will now turn to the Reports of St. Bartholomew's for the years 1889 and 1890, during which diphtheria was prevalent in that institution.

In 1889 the medical report records a total of 78 cases of diphtheria, of which only 33 recovered and 45 died. The surgical report gives 44 tracheotomies “for diphtheria and croup,” 22 being males and 22 females, and 32 being under the age of five. Out of this number there were 12 recoveries and 32 deaths.‡

In 1890 the medical report gives 148 cases of diphtheria,

* My only reason is to save space.

† It occurs to me as a possible fallacy that some tracheotomies may have been performed in the medical wards, but if so, they are not mentioned in the medical report.

‡ The medical report differs a little from the surgical, and states that in this year there were 47 tracheotomies with 10 recoveries.

with 91 recoveries and only 57 deaths. Thus the disease would appear to have been milder, or the treatment better, than in the preceding year. The surgical report gives 21 tracheotomies, with the splendid result of 18 recoveries and only three deaths. Surgery had here in all probability greatly helped the general statistics of the disease, and the result is the more satisfactory because all the patients were children and 17 of them under five years of age.

I visited the Hampstead Hospital for Fever cases at the invitation of my friend Dr. Gayton, its medical superintendent, in order to learn what I could as to their experience of diphtheria and croup, and especially as to the success of its treatment by tracheotomy. My visit was on April 28th, and Dr. Gayton and his assistant, Dr. Winter, were good enough to show me at least half a dozen children who were doing well after tracheotomy, and to give me much interesting information as to their recent experience. The hospital is well situated on a hill, and consists of many isolated, one-storied blocks, very roomy, well ventilated, and, it is needless to say, in excellent order. It was in the first instance designed as a smallpox hospital, but as smallpox is no longer admitted to any institution within the London district, it is now used exclusively for the other contagious fevers, and chiefly for scarlet fever, measles, and diphtheria. Although under parochial management, patients from all classes are admitted.

Dr. Gayton told me that the supply of diphtheria patients is tolerably constant, with some periods of temporary increase and reduction. He did not consider that they had recently had any epidemic of it or any remarkable local prevalence.

Many of the cases were, so far as he knew, isolated examples in the family, and quite without any traceable history of contagion. In many other cases, however, two or more children would be brought in from the same family, or there might be the history that brothers and sisters of the patient had suffered from sore throats, although not of sufficient severity to require treatment. "Do you make any distinction between croup and diphtheria?" I asked. "None whatever," was his reply; "it seems impossible to diagnose them." This avowal interested me much, fitting, as it does,

with opinions which I advocated long ago in a discussion at the Pathological Society. For me croup is catarrhal laryngitis, and diphtheria is catarrhal laryngitis propagated by contagion. They come under the general law that all catarrhal inflammations may become contagious. I was further told that the most practical classification of diphtheria cases (using that term as inclusive of all forms of pharyngo-laryngitis attended with membrane) was into those in which the disease had originated either from catching cold or from contagion, those in which it had followed scarlet fever, and those in which it had followed measles. Of these the latter class were, if tracheotomy became necessary, by much the least hopeful, whilst those in which no exanthem had preceded the disease ("simple diphtheria") were the most so. If tracheotomy were done in a patient who had had measles, the wound, I was assured, would almost invariably become unhealthy. This item of information again interested me very much, as fitting well with a former observation that measles is the usual parent of cancrum oris, and is of all the exanthemata the one most prone to initiate phagædenic or gangrenous processes. An unhealthy condition of the operation wound appeared to be Dr. Gayton's chief dread after tracheotomy, and the previous occurrence of either scarlet fever or measles was held to predispose to it.

As regards the general treatment of diphtheria, I was told that tracheotomy was resorted to in all cases in which death by asphyxia was threatened, but that in a considerable majority of the cases brought to the hospital it never came into consideration. The usual internal treatment was by the free administration of steel. Dr. Gayton has what he calls his "iron drink," upon which he places great reliance. It consists of the tincture of sesqui-chloride of iron liberally sweetened and largely diluted. Of this the little patient is allowed to drink freely whenever thirsty, and I was assured that it was not at all uncommon for a child of five or six years old to take in twenty-four hours from half an ounce to six drachms of the tincture. As a topical application the old-fashioned honey and borax is in much favour. Neither mercury nor antimony are ever prescribed. As regards

tracheotomy, Dr. Winter told me that their statistics began with last September. Previous to that date the mortality had been so high that they would prefer to leave the cases uncounted. Dr. Gayton confirmed this, and told me that he had been so much discouraged during several years that he was on the point of coming to the conclusion that it was safest to leave the patient to his chance without resorting to the operation. Last September (1891), however, without any obvious reformation in practice, there was a change for the better in the results obtained, and recently from half to two-thirds of the patients operated on had recovered. Almost the only definite point of change in treatment which Dr. Gayton could mention was the introduction of the bi-chloride spray for the wound. This had of late been most systematically attended to, and to this he was inclined to attach much importance.

The early and frequent changing of the tube was another point which had received recently more attention than formerly. Within twelve hours of the operation the tube is now invariably taken out and the trachea cleansed, and after this it is always removed once a day. I was assured that with a little management and with great gentleness patients could be induced to bear this quite quietly. An anæsthetic, chloroform, is invariably used at the time of the operation, but never for changing the tube. During the latter process the patient is placed with the shoulders on a pillow and the head thrown well backwards. As regards the removal of false membranes at the time of the operation, Dr. Gayton assured me that they had for long attended most scrupulously to it, and he did not think that their recent increase of success had any connection with increased care in that matter. As a detail in the performance of the operation, I was told that it was not usual to use the knife further than for the division of the skin and the fascia. This having been done, the operator, with two pair of forceps, would next tear through the cellular tissue between the muscles until the trachea was laid quite bare. By this precaution the division of veins and of small arteries was avoided, and the operation was often almost bloodless. After the operation

the patients are placed, as is usual, in a curtained cot with a steam kettle playing. They are treated in different wards under different nurses, and but little is usually done in the way of internal medication. The duty of frequently spraying the wound with the bi-chloride solution is strictly enjoined upon the nurse, who is held responsible should any unhealthy condition of it result.*

The picture painted by the facts which I have adduced is one of fitful lights and deep shadows. At one moment it would appear that tracheotomy for croup and diphtheria is a measure almost without hope, and at another that it is a highly successful procedure. There is not the least reason to believe that the discrepancy is, to any appreciable extent, to be explained by reference to the varying nature of the disease. The difference clearly is in the attention to the details of the operation and the after treatment of the case. If this attention be sedulous, unremitting and according to rule, it is probable that under all conditions a fair average of recoveries may be expected. If, on the other hand, the operator be content merely to do the operation and leave the rest to nature, it is obvious that it might as well be omitted. Tracheotomy for croup remains, in fact, a house surgeon's operation. In other words, the operator should be the surgeon who will have care of the patient afterwards, and he should be resident. It is only under such conditions that the necessary zeal and assiduity can be expected. It is also emphatically one of those operations in the performance of which it is most desirable that all young surgeons should be trained. I therefore make appeal to the many intelligent and highly educated men now holding these appointments that they should no longer permit this operation to occupy the uncertain position which it at present does. Success is clearly possible, and it ought to be attained.

(To be continued.)

* Dr. Gayton has since written to me stating that since September 28, 1891, till the present, 36 operations have been performed, with the result that 16 patients have left the hospital well—14 having died and six still remaining under treatment. The youngest of the patients operated upon was one year, and the eldest nine years.

NOTES ON OPERATIVE SURGERY.

No. XIII.—*On the Operative Treatment of Intussusception of the Bowels.*

It was my good fortune about eighteen years ago to perform a successful operation by laparotomy for intussusception. My case was, I believe, one of the first successes, and it naturally led to my taking great interest in the subject afterwards. It was a case in which the intussusception was a very unusual length, the inverted head of the cæcum projecting several inches at the anus. Since that time a certain number of successes by laparotomy have been recorded, and side by side with them a yet larger number in which the operation has failed to save the patient's life. In a not inconsiderable proportion of the latter, it was found impossible to effect the reduction of the incarcerated bowel.

I will place what I now have to say on the subject under a few definite heads.

Proposition I.—It is absurd to institute any comparison between treatment by insufflation or injection and that by laparotomy. The rule of practice ought to be invariably to try the former measures in the early stages. It is only when they have failed that laparotomy ought to be thought of. The two measures are not competitive, but the one is supplementary to the other. Statistical tables instituting a contrast as regards the relative success of the two measures are mere waste of labour.

Proposition II.—Whilst fully admitting that insufflation and injection treatment ought to be tried first, it is to be borne in mind that these measures are not without risk. They are to be practised with judgment and caution, and not perse-

vered in too long. In not a few instances when done too boldly, rupture of the bowel has resulted.

Proposition III.—It is probable that there is not much reason for preference for insufflation, or injection of air, over injection of water. If the latter is done, the patient's body should be in the inverted position, at any rate during part of the time. As regards the details of the process, I prefer to do it by hydrostatic pressure rather than by a syringe, believing that it is more easy to estimate the amount of distensile force which is used.

Proposition IV.—If the patient be an infant, say under two years of age, it will be well to be content with repeated attempts by injection. The results by laparotomy in infants have been so almost invariably fatal, that it is safer to trust to the other measures.

Proposition V.—If the patient be more than two years of age, and a patient attempt at treatment by injection have failed, a prompt resort to laparotomy is to be recommended. It is desirable that this should be done early before the serous surfaces have become adherent, or the reduction of the incarcerated portion had been made difficult by swelling.

Proposition VI.—In the performance of the operation the difficult part is the withdrawal of the incarcerated portion of bowel. It is very important to remember that this is often most easily accomplished not by traction of the upper end, but by pressure on the lower, or by the two at the same time.

Proposition VII.—The older the patient, the slower in all probability will be the progress of symptoms in intussusception, and the longer the period during which it is practicable to effect relief by operation. Thus in adults an intussusception case may be protracted over weeks and even over months. The conditions present even after a very long interval may still be such as to permit of a successful operation.

In formulating the above propositions I have made no reference to the question of diagnosis. It is usually easy. The tenesmus, the bloody mucus, and, above all, the discovery of a tumour by manipulation through the abdominal wall, render the diagnosis of intussusception in a majority of cases very definite. It must be admitted, however, that there

PLATE XLVIII.

FIG. 1.—INTUSSUSCEPTION OF CÆCUM.

THE upper figure in this Plate shows the commencement of an intussusception of the ileum and cæcum into the colon. The latter has been laid open, and the florid mucous membrane of the involuted bowel is exposed. To the right is seen the ileum, and by its side the terminal portion of the appendix vermiformis, just about to be swallowed in the progress of the intussusception. The sketch was taken by Mr. Frederick Mackenzie, many years ago, from a child who died in the London Hospital after a severe burn. It may be taken as a good illustration of the earliest stage of the condition of which the next Plate shows the completion. Intussusceptions are very common at this part of the bowel.

FIG. 2.—ULCERATION OF COLON FROM DISTENTION.

THE lower figure in this Plate shows commencing ulceration of the mucous membrane of an over-distended colon. At one spot perforation was just about to occur. The patient, an elderly woman, had died of exhaustion after nearly six weeks of almost complete obstruction of the bowels consequent on a malignant stricture. The diseased portion of the bowel was almost close to the stricture. The sketch was taken (many years ago) in order to exhibit the processes which in cases of long-continued obstruction precede perforating ulcer; and also the part most prone to be affected. The proper treatment of the case would have been a colotomy in the right loin. The portrait is a warning against too long delay of operative measures in similar cases.



PLATE XLIX.

INTUSSUSCEPTION PROJECTING AT THE ANUS.



IN Plate XLVIII. is shown the commencement of an intussusception beginning with the ileo-cæcal valve. In the present one we have illustrated the final condition of this lesion, the ileum having travelled the whole length of the colon, and appeared at the anus. The ileo-cæcal valve itself still forms the apex of the involuted tract. The appendix cæci, completely swallowed, being of course in contact with the peritoneal surface, is concealed from view. This portrait is of especial interest as showing the exact condition of things which was present in the case upon which I operated, and which is referred to at p. 25. In that case, during the operation, when the involution was drawn out, the last structure to make its appearance was the appendix cæci. This drawing was from a child in which the disease, after the usual symptoms, had ended fatally. It will be seen that there are not the least indications of the usual tendency to gangrene, nor any evidences of tight strangulation. So far as appearances go, had an operation been performed, a reduction would probably have been easy.

The sketch represents the orifice of the anus, and the structure turned to the left is the urinary bladder. At the opposite end a probe has been passed into the intussusception, by the side of the contained gut.

The original drawing from which this Plate is copied was given me by Professor Gairdner, of Glasgow. It is a very valuable one, and I do not know of the existence of any other.



are cases in which it is not so easy. I would venture to urge that in all cases of abdominal obstruction which present any symptoms similar to those of intussusception, and in which the injection treatment under an anæsthetic has failed after a fair trial, that the abdomen ought to be opened.

In the treatment of intestinal obstruction in general, it is a most important clinical rule that the first measure should be to put the patient under the influence of an anæsthetic. This should be done at the earliest possible period in the case. It has the double object of facilitating diagnosis and permitting those measures of treatment which are comprised under the term "abdominal taxis." Under this term I include systematic manipulation, inversion of the patient's body, vigorous shaking of the body in the inverted position, and the administration of enemata, also in the inverted position. By these measures carefully carried out in an early stage I believe that in a majority of cases of mechanical obstruction of the bowels success will be obtained, and if it be not, an operative procedure will probably be necessary. This procedure must either be a colotomy or a laparotomy. The choice will depend upon the diagnosis which seems most probable, as to the position and character of the obstruction. If the case be one of intussusception, it will be very rarely indeed that there can be any doubt as to the diagnosis after an examination in this manner.

No. XIV.—*Laparotomy for Impacted Gall-stone.*

I find recorded in the *Lancet* for May 21st, by Dr. Brockatt of Great Malvern, a case of much value in reference to the symptoms and treatment of gall-stone plugging of the intestine. The case so strongly supports the opinions which I have expressed on this subject that I cannot resist the temptation to reproduce it, and to state it in a schedule on the "space for time method." In this form it may easily and profitably be compared with the case given in Vol. III., p. 9. The two are very closely similar. I have insisted strongly that in these cases there is often no history of pain during the escape of the stone through the common duct, and the

symptoms often only begin when the intestine is plugged. The frequency with which the symptom of jaundice is wholly absent has also been clearly brought out. These points are well exemplified in Dr. Brockatt's case, for both pain and jaundice appear to have been quite absent. Nor, although the stone was very large, was there much evidence of its having previously caused trouble.

I have Dr. Brockatt's permission to republish his case, and he has also been good enough to give me the additional information that the stone weighed two ounces. It was clearly a very large one. It is now, I believe, in the Museum of St. Thomas's Hospital.

A Case of Gall-stone Plugging. Symptoms of a bilious attack. No pain. Much vomiting. Operation on ninth day of illness, and a large gall-stone removed from jejunum. Death five days later from Peritonitis. Dr. Murphy and Dr. Brockatt. (See the Lancet for May 21st, p. 1130.)

DATE.	DAY OF ILLNESS.	DETAILS.
Dec. 20	3	First seen by Dr. Murphy on the third day of a "bilious attack," which had been attended by vomiting. <i>No pain.</i> Three days' constipation. Normal temperature. Anxious expression. Great thirst.
" 21	4	No note.
" 22	5	Slight action of the bowels; less vomiting. Patient feeling better. Enemata followed by three large stools.
" 23	6	Patient ate some chicken. The vomiting returned, and large quantities of bile were ejected.
" 24	7	Much in the same condition. <i>No pain.</i>
" 25	8	Vomiting still persisted, and the matters ejected "very offensive." Abdomen much distended. <i>No pain.</i> Tongue dry and brown. Pulse 120.
" 26	9	OPERATION (under anæsthetic, a hard, freely moveable mass easily felt). Abdomen opened and a large gall-stone, which plugged the jejunum, removed.
" 27	10	Doing well. Temperature normal; pulse 96. <i>No pain</i> ; no vomiting.
" 28	11	Doing well.
" 29	12	Very weak.
" 30	13	Still more weak.
" 31	14	Died from exhaustion and peritonitis (sixth day after operation).

Post mortem.—The autopsy showed slight but definite evidences of peritonitis. The incision in the intestine was well united. The stone was pear-shaped and two inches long, and five and a half in greatest circumference.

No. XV.—*On difficulties in the Diagnosis of Tumours under the Sterno-cleido Mastoid Muscle.*

I quote the following, with feelings of much sympathy, from a Japanese medical journal :—

“ Dr. J. Kimura brought before the Society a woman of 23 years old, who began to have a swelling in her neck, which at present occupies the side of the neck, from the mastoid process to the point two inches above the clavicle. Dr. Oka said it will be a cystic tumour, Dr. Sewaki believed it a tubercular lymphatic glands, Dr. Sasaki lymphosarcoma, Dr. S. Kimura a cystic tumour, Dr. S. Suzuki an abscess originating from tubercle in lymphatic glands, and President Takaki a cold abscess.”

There is perhaps no class of tumours which present greater difficulties in diagnosis than those which occur in the neck. Witness the very interesting case recently recorded by Mr. Croft, in which a tumour, supposed to be an abscess, was found to communicate with a vein, and ligature of both artery and vein were required. I have myself recently had under observation two cases in which fusiform swellings, possibly gummata, occurred in front of the carotid and partially surrounded it, simulating aneurism. In one of them I could not for some weeks feel quite sure that it was not an aneurism. We may remember that Liston, in the case of a young boy, opened what he supposed an abscess, and had to tie the carotid for aneurism. The precise nature of this case was never satisfactorily established.

The case which puzzled the Medical Society of Tokyo does not, however, appear to have been one in which the blood-vessels were concerned. Under the upper third of the sterno-cleido mastoid we may have the peculiar potato-like tumour (a lympho-sarcoma), to which I have repeatedly asked attention. We may have also a very peculiar cystic tumour, which bulges both in front of and behind the muscle. This cystic tumour will often in adult age inflame and suppurate. It is almost impossible to dissect it out, and exceedingly difficult to get it to cease secreting after it has been opened. Next, it is not very infrequent for a gland in this position to suppurate

slowly and constitute a very large, thin-walled cavity, exactly like the cyst just described, and wholly without inflammation. The exploring trocar is the only means by which to decide whether such a tumour contains this glairy pus or transparent cyst-fluid.

No. XVI.—*Note on the History of Operations for Varicose Veins.*

In the beginning of the present century the ligature of veins for the cure of ulcers was not uncommon. Sir Everard Home recommended it, and spoke lightly of its risks. That the latter were not inconsiderable, however, is made quite clear by the medical literature of the period. Phlebitis and pyæmia, followed by death, appear to have occurred every now and then. Mr. Oldknow of Nottingham, writing in the *Edinburgh Medical Journal*, states that he had been taught to consider the operation a very trifling one, but he records a case in which his patient, a healthy young man of twenty-three, died on the twenty-second day, with symptoms which, at the present time, we should certainly regard as those of pyæmia. The saphena vein just below the knee had been tied in an open incision. The use of antiseptic applications, and the great care as to cleanliness, &c., have together in the present day all but absolutely deprived these operations of danger. I can well remember a time when they were looked upon with considerable disfavour in most of the London hospitals, and although no great number of operations were done, I yet also well remember a few instances of disastrous consequences.

No. XVII.—*On Causes of Death in Midwifery.*

The statistics of midwifery, and the causes of death after childbirth, are not without their interest for the operating surgeon. To a considerable extent the same kind of risks are encountered after delivery as after a large operation wound, and the same kind of precautions are needed.

My friend Dr. Aveling, one of the highest authorities on these matters, assures me that in spite of all modern improvements in practice, the ratio of mortality after parturition in

English practice has not been reduced lower than one in two hundred. The chief triumphs of recent days have occurred in the reduction of mortality in Lying-in Institutions. In private practice it is probable that for long the ratio has not been higher, and that no great change has resulted recently. It would appear, to judge from the statistics of individual practitioners, that it is very difficult even under the most favourable circumstances to beat the record.

I have before me a number of the *New Zealand Medical Journal* which contains the statistics of 2,590 cases occurring in the practice of one surgeon (Dr. Sealy). They give a mortality of 1 in 259, being just a little better than the average. It will be seen from the following list of causes of death that something of the nature of puerperal fever claimed about half.

- 1 from scarlet fever, 11 days after confinement.
- 1 from acute pericarditis, 2 days after delivery.
- 1 from uterine inflammation and fever, 18 days after.
- 1 from post partum hæmorrhage, half-hour after delivery.
- 1 from the effects of hæmorrhage, 2 days after delivery.
- 2 from puerperal fever, each 9 days after delivery.
- 2 from typhoid fever, 12 and 10 days after respectively.
- 1 from bronchitis, 3 days after. (There was no particular temperature, and nothing septic in this case.)

DISEASES OF THE NERVOUS SYSTEM.

No. XXXVI.—*Symmetrical Mydriasis with Cycloplegia (Ophthalmoplegia interna)*—Four years' interval between the attacks in the two eyes, and of a sort of seizure in connection with each.

The peculiarity of the case I am about to narrate is that the patient has sustained loss of accommodation in both eyes, together with dilatation of the pupil, but without other symptoms of defect of third-nerve muscles. Nor has he any of the usual indications of commencing tabes. Mr. W——, a rather spare, very healthy-looking man, brought me a letter from a professional friend, three sentences of which thus summed up his case: "He is a rheumatic subject, and has had ague and syphilis. Some years ago his left pupil became dilated, with some loss of vision and focussing power. Now the right eye has followed suit." In pursuing the hints thus given, some very interesting details were elicited. I did not succeed, however, in arriving at any definite diagnosis as to whether this very exceptional condition ought to be attributed to syphilis or to ague. The patient's condition was—pupils dilated to the size of No. 11, and fixed; unable to read excepting with +10, and being somewhat hypermetropic, needing +40 for distant vision. The fundus of each eye was normal, and he had no iritic adhesions. Excepting these conditions in his eyes he had no other symptoms of ill-health, and those which he described in the past chiefly had reference to the ague from which he had suffered. He had no headache; he could walk quite well with his eyes shut, and he had had no bladder symptoms nor any definite ataxic pains. If he had ever had syphilis, it was five and twenty

years ago, and nothing had since occurred to remind him of it. He had suffered severely from ague when a young man living in the marshes near Gravesend. Through life ever since he had been liable to feverishness and aching pains whenever exposed to cold, and he had taken much quinine. The greater part of his life had been spent in districts not wholly exempt from malarious influences. He had been married for twenty years, had two healthy daughters, and had lost no children. His own expression as regards his eyes were: "Four years ago the pupil of my left eye enlarged, and now the other has gone too." He asserted that on each occasion the dilatation of the left pupil, and accompanying defect of sight, were preceded by a sort of seizure, which he described with much detail. It appeared, however, on carefully questioning him, that the failure of the eyesight was noticed a day or two before the first so-called "seizure," and that on the second it did not follow for a day or two afterwards. The fact remained, however, that of these "seizures" he had had but two, that the interval between them had been four years, and that one of the eyes had been affected after each. He described his last seizure as follows: "I had gone down to Brighton quite well, but found myself tired with the journey, and was feverish and had aching joints, as if ague was threatened. I took an opening pill; was very feverish through the night, and the next day had diarrhoea and felt languid. On going upstairs to bed I felt faint, and had a dreadful buzzing in my right ear, as if a champagne-bottle had been uncorked close to it. My wife helped me to a chair. I did not faint or lose consciousness; and in two or three minutes the sensations in my head died away, and I broke out into a profuse perspiration. The next day I was better, but on the following morning I found that I could not see well, and that the pupil of my eye was enlarged, as that of my left had been for four years." Respecting his first attack he could not give so much detail, but he remembered that the "terrific buzzing" in his ear had lasted much longer than on the second occasion, and that it had been followed by "a dreadful sweat." It also had occurred just as he was going to bed, and after he had been, for several days, not feeling well. As far as he could remember, the left

eye had failed two or three days before the attack. No improvement whatever had followed from any of the remedies which he had used, either after the first or the second attack. The pupil had remained on each occasion dilated and motionless, and the defect of sight now amounted to almost complete loss of accommodation. On neither occasion was he actually taking quinine at the time of "the seizure."

There is but little else that seems worthy of mention in Mr. W——'s case. He had never had squint or definite double vision. His upper eyelids did not droop in the least, and I could not detect any imperfection in any of the external third-nerve muscles. His knee-jump was very excessive. It occurred with extreme rapidity, and unless he made voluntary effort to prevent it, was attended by movement of the arm on the same side. Constipation had been a very troublesome condition through the whole of his life. He had sometimes experienced shooting pains in the knees, which had been called rheumatic. It will be seen that the condition of the pupils present in this case is, as regards size, the converse of what is usual in ataxy. We do, however, occasionally in this malady see the pupils dilated instead of contracted.*

No. XXXVII.—*Burning pain in the limbs of one side as a symptom of Brain Disease—Liability to temporary Aphasia—Epilepsy, Melancholia, Mania, and Death.*

Dr. Lyle, of Dunmow, brought to me a married man, aged 37, whose chief complaint was of a burning sensation down the outer side of both upper and lower limbs on the right side. He said that the burning was such that he could scarcely bear it. He had, however, other and much more definite symptoms. His speech was slow, and his thought-processes were clearly very dull and imperfect. He had no knee-jump whatever, and his pupils were rather large and sluggish. There was a history that three months ago, whilst

* Whilst this sheet has been in the printer's hands a somewhat similar case has come under my observation.

driving in his dog-cart, he had had a fit and fallen out. After the fit he was able to get up again and catch his horse; but it was followed for a time by aphasia. His wife stated that now and then during the last twelve years—that is, the whole of their married life—he had been at times unable to speak. On the whole, however, he had enjoyed good health, and had never needed medical advice. There was a history that a few years before his marriage he had suffered from syphilis. I examined his optic discs and found no changes. He could walk fairly well, and could maintain conversation, although, as stated, it was slow and without animation. It was on October 7, 1890, that I first saw this patient; and he was brought to me for a second time on December 4th. In the interval he had had several epileptiform attacks, and his memory had very decidedly failed. He had become dull and melancholy.

Two or three months after his last visit to me the patient was seized with mania, and had to be removed to a lunatic asylum. His raving was violent, and continued, I was informed, up to the time of his death, which occurred about three weeks after his confinement.

In the absence of post-mortem evidence, it may be conjectured that the lesions were cortical, and that the disease was a form of general paralysis of the insane. I have thought it worthy of record on account of the peculiar burning pain in the right limbs which proved to be so ominous as a symptom.

No. XXXVIII.—*A peculiar form of aggressive Hemiplegia of four years' duration, and characterized by numbness and subjective coldness rather than real anæsthesia—Paralysis of common extensor of toes.*

Mr. J——, 63, a healthy-looking man. Four years ago, whilst sitting at the fireside, he suddenly felt a numbness in the left arm. "It went up the arm, down the side, and to the leg." He was worse next morning, and stayed in bed an hour or two; but when he got up he could stand. At first there was only numbness, but gradually loss of power came

on. He was never disabled from walking, and never had retention of urine. Throughout, sensation was affected in excess of motion. His face was never paralyzed, but he says that his ear feels numb. He can make mouths. He complains that he cannot touch cold things with his left hand, as it sends a pain up his side and into his leg. He has a sensation of cold in the left side of face; when he puts it on the pillow it feels painfully cold. He says that he cannot use his toes except the big one. Knee-jump excessive on left side and good on right. There is nothing whatever to be observed in the hand or forearm. Their nutrition seems perfect, and he uses all their muscles well. He complains, however, that use of the hand makes it ache, and that it feels numb. There is no difference in special muscles.

He considers that the conditions described have been gradually increasing ever since he was first taken, four years ago.

There is no real anæsthesia, but a general sensation of numbness and coldness. No wasting or contraction of muscles, but he cannot use them easily, and they ache after use. Sometimes he has difficulty in straightening his knee, and the muscles feel stiff. He uses the long extensor of the great toe well, but cannot use the extensor of the other toes more than a very little. The toes of both feet are in the hammer position, the great toe being excepted. The inability to use the extensor of his toes has been present ever since he was taken. Sight and hearing good.

I narrate this case, as the preceding one, on account of the singular character of the principal symptoms which attended it.

No. XXXIX.—*Recovery after fracture of base of skull, with permanent paralysis of the third and fourth nerves on the right side.*

On February 15, 1884, I saw at the Poplar Hospital, with Dr. Brownfield, a patient of his who had recovered after probable fracture of the base of the skull. The chief feature of interest in the case was that it seemed likely that the trunks of the third and fourth nerves had been torn across.

The man, at the time of my visit six weeks afterwards, had still the symptoms of complete paralysis of these nerves, and of none others. The eyeball diverged, and could not be moved either inwards, upwards, or downwards; nor when told to look upwards or downwards was there the slightest rotation of the eyeball on its axis. The pupil was widely dilated, and accommodation was quite lost. We did not get his vision very accurately, but I ascertained that he could read large print with a convex glass, and I was told that the ophthalmoscope revealed no changes in the disc. The eyelid drooped so as to entirely cover the eye.

The injuries in this case had been caused by the man falling into the hold of a vessel. He had remained where he fell for twelve hours before he was found, and was then taken up insensible. There was slight bleeding from the right ear, and much bruising upon several parts. When I saw him, he had quite recovered, and enjoyed the full use of his faculties. He complained that his right arm was a little numb and weak, but there was nothing very definite. He was not deaf in the right ear, and there was no paralysis of either portio dura. His lower jaw had been fractured. I was told that he had been delirious, pulling his bandages off, &c., during the first fortnight. There had never been any serous discharge from the ear, and probably the bleeding which had occurred had been only from the external parts.

No. XL.—*General muscular debility in a young child—Rapid decay of temporary teeth—Syphilis suspected—History of profuse and almost fatal hæmorrhage from the vagina in very early infancy—Obstinate constipation.*

Mr. C——, of T——, sent me a case of much interest and of great difficulty as regards diagnosis (May 10, 1886). The child, a girl of two and a half years, could neither walk nor talk, and was only just beginning to crawl. All her teeth were cut, and all were fast rotting away level with the gums. The child was fairly well grown, of good complexion, and although her forehead was prominent and a little peculiar,

the skull showed no bosses. There was no history of syphilitic symptoms in infancy. She was the first which had lived. Two previous conceptions had ended, one in a dead child after a difficult labour, the other in a premature birth at six months. The facts just mentioned, coupled with the father's confession to having had syphilis five years or more before marriage, had led to the prescription of specifics for the mother. They were taken with some irregularity during the whole of the third pregnancy. Since the birth of this child, another, a boy, had been born who was now aged six months and in excellent health.

I saw both parents, and they appeared to be exceedingly well. The father, who was quite candid, had not had any reminders since his first treatment. We had to account for remarkably slow development, with soft, flabby muscles, especially in the lower extremities, coincident with rapid decay of all the milk teeth.

I was inclined to attribute the latter to the mercury which the child's mother had taken through her pregnancy. Two facts as to the child's infancy have yet to be stated. When two days old, she bled from the vagina (or bowel) continually for forty-eight hours, and became so weak that she was unconscious, and it was not thought possible that she could live. Her mother holds that she never got over this, and perhaps she is right. The next fact is that the child through her whole infancy was constipated to an extraordinary degree. Was this a cerebral symptom? Did it denote defect in nervous system, and especially in vaso-motor?

The child reminded me of certain cases of infantile cerebral paralysis, but there was no paralysis, only flabbiness and debility. This state was greater in the lower extremities than the upper ones. She could hold things in her hands fairly well. No convulsions had ever occurred in infancy. She was very good-tempered. I examined one eye with the ophthalmoscope, and found no peculiarities excepting that the retinal vessels were small and that there was a large crescent of pigment on the edge of disc.

Does extreme constipation in infants usually go with defect of the cerebro-spinal system?

I advised that there was no proof of syphilis, and perhaps not much probability of it. The case to be treated on general principles and without specifics.

No. XLI.—*The beginnings, or early symptoms, of Tabes.*

A case of great interest, as illustrating what was, I have no doubt, the early stage of locomotor ataxy, came under my care in March, 1889 (Mr. L——). The patient, a very healthy-looking gentleman of fifty-one, had had what he called "bladder troubles." They had begun by a too frequent desire to micturate, which was soon followed by frequent escape of urine both in the day and night. The desire, although frequent, had never been urgent, and he would frequently have incontinence without having experienced any desire whatever. A urinary specialist whom he consulted proved to him by the use of a catheter that he had habitually a large quantity of residual urine, and advised the employment of an instrument three times a day. This plan had been carried out for about fourteen months before I saw him. On first rising from bed in the morning, he could, with a little patience, succeed in nearly emptying his bladder. In the afternoon he again used his catheter, and again on going to bed. In this manner he managed to escape any discomfort from incontinence. He had never had any characteristic tabetic pains in the legs. His knee-jump was still moderately good, and he could walk, he said, five or six miles without fatigue. In spite, however, of the absence of the pains, &c., the following symptoms seemed to me to justify the diagnosis of impending tabes. He complained very much of a sense of fulness and weight in his abdomen, as if it were constricted. He had for a time, six months ago, been what he called "groggy on his legs," and at this time one of his pupils, the left, had been widely dilated. The pupil had recovered, and both were now of normal size, and, though very sluggish, were capable of a certain degree of contraction and dilatation. He said that he frequently experienced slight muscular twitchings in his legs, what he called "live blood."

As regards the possible causes of tabes in this case, the patient admitted having had syphilis five and twenty years ago. For it he took mercury, and apparently got quite well, having never since had any reminders. He had been married for nearly twenty years, and had a family of healthy children. He had worked very hard in professional life in London, and as bearing on the question of defective tone as a cause of his symptoms, he had noticed that his power over his bladder always increased during a stay at the seaside. He had also experienced great benefit from nux vomica and valerianate of zinc, and he thought that the iodides had always made him worse. He had already consulted several nerve specialists, two of whom had told him that syphilis had nothing whatever to do with his symptoms, while another had expressed doubt. My advice to him was to abstain entirely from sexual intercourse, to avoid the iodides, and to take small doses of mercury combination with nux vomica.

No. XLII.—*Tabes characterized by very severe pains during twenty-five years—Charcot's Disease of one Knee-joint.*

An important example of tabes denoted almost solely through a long series of years by pains in the lower limbs, but attended ultimately by a disorganized knee-joint, was brought under my notice by Dr. S——. Our patient was an elderly gentleman (Captain R—— H——), aged 68; he had suffered from syphilis in a mild form about forty years ago, and for nearly thirty he had been liable to most severe shooting pains in his limbs. He had married five or six years after his syphilis, and his pains were at their worst about seven years after his marriage. From this time, and for ten years onwards, he was never free for more than a week or two at a time. Both his wife and he agreed in describing the pains as having been of terrible severity; they used to keep him awake a whole night. During the last ten years these pains had been much mitigated, though by no means absent. He had suffered, however, a great deal from want of tone in the bladder, and inability to empty it. He

had often had cystitis, and had been compelled to use a catheter a good deal. Until quite recently he had been able to walk well, and had experienced no failure in his general health. In this respect his case is very similar to that of Dr. —, of H—, who has for thirty years been liable to great suffering from tabetic pains, but who has not developed any other symptoms. Captain H— was brought to me on account of the condition of his right knee-joint. It was full of fluid, the synovial pouch passing up the anterior third of his femur. The tibia was loose, and there were evidences of bony outgrowths, and there are irregular thickenings both in it and the femur. He had no material pain in the joint unless he took exercise. The joint had been aspirated a few weeks before I saw him, and sixteen ounces of synovia removed. It will be observed that it had been a sub-acute affection, for the joint had been perfectly well until within about two or three months of my seeing him. He had then had an attack of general swelling of the limb, supposed to be due to venous thrombosis. In confirmation of the diagnosis of tabes, it may be added that his pupils were motionless, his knee-jump quite absent, and that he could not walk with the eyes shut.

DISEASES OF THE SKIN.

No. LVI.—*Some general considerations as to Acne.*

If we would correctly interpret the phenomena of acne, we must begin by calling to mind the fact that in the human subject a general but irregular suppression of hair-growth has taken place. With the exception of certain regions, man has ceased to be a hair-protected animal. The sebaceous glands, which are originally adjuncts of the hair follicles, have at the same time undergone great modification. On most parts of the skin they have no doubt been much reduced in number and in size. In some they have become liable to occlusion of their orifices, and in many they have ceased to open into hair follicles and have their orifices on the surface of the skin. Although growth of hair has in many parts entirely ceased to occur, yet partially developed hair follicles still exist and receive into their necks the ducts of the sebaceous glands. On certain parts of the body in the human subject no tendency to suppression of hair has as yet been observed; these are the scalp, the armpits, and the genitals. On others, as for instance the face and certain parts of the trunk, the growth of hair varies with the race and the sex. The suppression of hair in general has been far less complete in the male than in the female sex, and whilst hairy men are common, it is very unusual to see any differences in different women as regards the tendency to grow hair in unusual positions. As a general law the suppression of the sebaceous system is in ratio with that of the hairs, though far less complete. In women the sebaceous glands are fewer in number, smaller in size, and less active in function than in men. The limits of variation are also much more restricted in these respects in women than in men.

From a consideration of the facts above recapitulated we

may obtain valuable assistance in the consideration of such diseases as those known respectively as Acne, Sycosis and Lichen. If for classification purposes we give these names anatomico-pathological definitions, they would probably be much as follows. When the orifice of a hair-follicle having no hair becomes the seat of chronic thickening, we name the little firm papule thus produced "Lichen." When a hair-follicle, containing a hair, inflames and suppuration ensues, and the lining membrane is loosened so that it may be pulled away with the hair, we name the disease "Sycosis." When a sebaceous gland (formerly the appanage of a hair now suppressed) becomes, first distended with its own secretion and then inflamed, we name the condition "Acne." It will be obvious, however, that the conditions described can be appreciated, as distinct, only when they are well marked, and that there must be many instances in which they are mixed. For working purposes, however, these definitions will be found sufficiently accurate. Sycosis can occur only in parts where hairs grow, for it is disease of the follicles. Acne, on the contrary, can occur only where sebaceous glands are met with which have no hairs in connection with them. If hairs were present their follicles would be involved, and it would become sycosis at once. Lichen is a less well-marked affection than the two others, and differs from them rather in the type of the inflammatory action than in the structure affected. If a lichen papule should tend to suppurate, it would probably be called either sycosis or acne. In many instances lichen papules are indeed a stage of acne, whilst in others they are a part of eczema. In any case we name the disease as a whole, not so much from the peculiarities of individual elements as from the general character of the whole. The terms lichen-eczema and lichen-acne are both of them perfectly well founded on real conditions and tendencies, and are very useful in practice.

If we now confine our attention to acne, certain *a priori* propositions appear to be justified by the facts which have been cited.

Inasmuch as the endowments in different individuals in respect to number and size of sebaceous glands vary very

much, so ought we to expect the tendency to acne to vary. Since, as a rule, the sebaceous system is less developed in women, we may expect acne to be more common and more severe in males. This expectation is, however, to some extent controlled by another consideration which tells in the other direction. The development of hair appears to give to the sebaceous glands a healthy stimulus and to prevent their passing into morbid states. Thus men in whom hair is very abundant on the face rarely suffer from acne. Lads who at and after puberty were liable to acne often lose it as the facial hair develops. Men who have much hair on their backs rarely suffer from acne in that region. In women, however, the whole of the facial hair is suppressed, so that they lose its beneficial influence. Thus, although in them the glands are neither so large nor so numerous as in men, yet they are prone to suffer frequently from acne. The acne of girls, however, is almost always confined to the face, and it is very rarely so severe as it often is in young men. Backs covered all over with comedones and acne-furuncles which we so often see in young men are fortunately seldom or never witnessed in the opposite sex.

No. LVII.—*Cacatrophia Folliculorum.*

Under the name *cacatrophia folliculorum*, the late Dr. Tilbury Fox described and endeavoured to specialize certain conditions allied in part to lichen and in part to acne, in which the skin becomes rough owing to prominence of the orifices of the hair follicles. The parts usually affected are the outer surfaces of the upper arms, and the patients who present this condition are almost always young women. Every one will be familiar with the condition named who has paid attention to the state of the skin on the parts mentioned in young women of a rather feeble circulation. It is very common indeed in slight degrees, and is but seldom allowed to count as a disease. It is rather a peculiarity of the skin, and it usually persists during many years, but, I think, disappears gradually when adult-life is established. The often-quoted comparison of the skin to "a nutmeg-grater" is very appropriate for the more marked cases, and the special locality

affected almost in itself gives the diagnosis; for it is never seen on the flexures, and although it may be present in other parts it is invariably best marked on the backs of the arms. Dr. Tilbury Fox's description seemed to me to be clinically correct, and although I do not find that it has received much recognition by subsequent writers on skin diseases, I yet think that his name is a convenient one. It should be observed—and it is surely a decided advantage—that it is a name for a pathological condition and not for a special disease, or, as the phrase is, a morbid entity. A less than perfect state of nutrition of the hair follicles persisting for a long time, but not attended by any acute inflammatory disturbance, is of frequent occurrence, and may become an element in more than one of the affections of the skin which have received special names. It depends probably quite as much on the original endowments of the skin, its congenital peculiarities, as upon any influence which has been brought to bear upon the state of health of the individual; and, if we admit this, it follows that it is likely to vary with the special conditions as regards the structure of the skin of each individual patient.

I have made the above remarks as introductory to the description of a group of very peculiar cases in which very minute papules are produced on the face and other parts in connection with follicles. The peculiarity of the cases consists chiefly in the extreme minuteness of the changes. It may be noted also that they are always symmetrical, and that they begin in very early childhood. Although I have no doubt that I have seen this condition in a good many patients, I have only taken special note of its peculiarities in two or three: of these the following is one of the best examples: Lady E—— H—— brought to me her daughter (who was a very fair-complexioned and florid girl, with a thin, transparent skin) on account of an eruption on her face. The eruption involved the middle of the forehead just over the root of the nose, both eyebrows, and the parts of the cheeks which in a man would be occupied by the whiskers. It was also present to a very slight extent on the nose. It was most conspicuous on the forehead, and here it consisted of

little hard, dry papules, none of them bigger than pins' heads, and many not nearly so large. They were scattered thickly over the skin of the part named, the tendency to them ceasing gradually on the forehead. The whole of each eyebrow was involved in a similar condition, though the changes were yet more minute, and the same is to be said of the cheek-regions in front of the ear. A slight degree of congestive redness of the surface attended the disease on all parts, but nowhere was there the least tendency to the formation of pustules or acne spots. The disease might have been named with equal propriety a lichen or a minute form of acne. As disconnecting it with the causes of the common types of the latter disease, and as distinctly associating it with Devergie's lichen pilaris, it must be added that the condition had been noted in very early childhood, and that the patient was as yet only thirteen years of age. On the arms the deltoid regions were covered with similar but larger spots, and there were some also down the backs of the arms. I must add that there was a very slight tendency to ophthalmia tarsi, that is, there was a little secretion adhering to the roots of the eyelashes, but neither on the eyebrows or eyelids had any of the hairs been destroyed.

No. LVIII.—*Racial peculiarities as regards Acne.*

It would be of interest to know any peculiarities which acne may assume in reference to race, and I think it worth recording that the very worst case of acne on the trunk which I ever saw was in a Japanese. This gentleman, who appeared to be in good health and was aged twenty-four, showed me a few insignificant acne spots scattered over his face, and more especially on his chin. There were not more than half-a-dozen which had become pustular. On making him strip, however, I found his chest and back covered with scars, and large acne pustules. Many of the latter had suppurated and needed to be opened. There were very few comedones, whereas I never saw the skin of an Englishman affected with acne to anything like the same extent without there being also abundant comedones. The severity with which the chest suffered

was remarkable, the acne passing down nearly to the navel. On the back it passed down upon the loins and even to the hips; and on the arms, after covering the deltoids, it extended in a more sparing manner to the elbows.

No. LIX.—*An Erythematous and Thrombotic eruption occurring in the limbs of a healthy infant—Spontaneous recovery.*

The following is an extract from a clinical lecture which I gave some years ago at the London Hospital, with the patient before my class. It describes an acute erythematous eruption, which occurred, without obvious cause, in an infant, and which disappeared spontaneously. I am not now better able to name the malady than I was at the time, and I place it on record in the hope that others may be found to go with it, by the help of which we may eventually be able to recognize its real nature.

That the eruption was allied to urticaria is, of course, an obvious suggestion. The limitation of the eruption to the limbs, the almost complete absence of irritation, and the thrombotic developments are, however, features in which it definitely differed from that malady. That it was caused by some unrecognized error in diet on the part of the mother is not improbable.

Extract from Lecture :—

“The infant before us is, as you see, practically well, and she has recovered from an eruption which looked very alarming at the time of her admission. Yet we have not adopted any active treatment, nor indeed have I been able to give the disease any definite name. The child was sent to me by Dr. Edwards, of Keston, and its mother, who brought it, appeared to be in excellent health. She told us that she had two older children at home, neither of whom had suffered from any eruption. The infant herself, in spite of the state of the skin, appeared to ail little or nothing. She is eight months old, and has cut several teeth.

“Let me now describe the eruption. It affected the face, and the four extremities, entirely exempting the trunk; but

covering those parts of the hips and shoulders which belong to their respective limbs.

"It was symmetrical. It consisted of large, irregular, map-like areas of erythema, or of reddened skin, most of them abruptly margined. These underwent very rapid changes, being at first simply erythematous, then becoming livid, and subsequently brown. Only during the very earliest stage was it possible to make the colour disappear by pressure. Subsequently, it was clear that thrombosis and blood-staining of the adjacent parts were a chief part of the process. The last stage was a brown mark, often very irregular in shape, and so deeply tinted that the patches looked just like superficial moles.

"Fresh patches appeared day by day, and there were always some in various stages present at the same time. The eruption had been out for about ten days when the child was admitted; and you will remember that I discussed at the time various hypotheses as to its nature and cause.

"For various reasons, I put aside the *prima facie* suggestion that it was due to inherited syphilis. The eruption had come out too suddenly and too severely, and passed through its stages too rapidly. There was, besides, nothing in the child's appearance, nor in the family history, to support, in the least, such a supposition. My next thought was, that it was probably one of the multiform eruptions which occur (in connection with idiosyncrasy) from the administration of the iodides and bromides. I should still think this suggestion probable, were it not that the mother assures me that no medicine had been given."

No. LX.—*An Eruption caused by Vanilla.*

Dr. Cotman sent to me for inspection three boys who were engaged in a Vanilla factory. They had all become the subjects of a copious eruption of very minute lichenoid spots over the whole face and forehead. There was present also slight erythema and a little desquamation in parts. The rash was almost confluent. The boys said that the vanilla stained their hands, but they did not consider it irritating. Their

hands looked dusky and were slightly erythematous. The eruption was probably fading when I saw it. Dr. Cotman had in the first instance been consulted by one of the boys, and had on inquiry discovered the others.

No. LXI.—*Recurrent Varicella—Question as to hereditary Syphilis.*

A little girl, three years old (Miss W. W——), was brought to me under the following circumstances. I had attended her father for syphilis, and, four years after the disease, had told him that he might quite safely marry. He had done so, and both he and his wife had remained in excellent health. Their only child, my present patient, was born about a year after the marriage, and was carefully watched in infancy by a surgeon who knew the father's antecedents. Nothing in the least suspicious of syphilis occurred during infancy, but when two years old, the child went through a mild attack of chicken-pox. It cleared away completely, but some months later (statements differ as to how many) a rash, exactly similar in character to the first, made its appearance. It was scattered over the body and limbs, and was distinctly vesicular. I received a full written description of this eruption from the family surgeon, who informed me that he had at first given arsenic, but with no good results, and that subsequently grey powder in half-grain doses, night and morning, had appeared to cause subsidence of the symptoms. The improvement had, he said, seemed most definite, and had led him to diagnose the eruption as syphilitic. The tendency to recurrence of the spots had, however, by no means come to an end. Fresh spots had constantly reappeared, and though they did not cause much discomfort to the child they greatly distressed her father. The character of the eruption had, I was informed, become somewhat modified, being in many places bullous rather than vesicular.

I found the little girl florid and healthy looking, and without the slightest indication of inherited taint. The eruption was symmetrically scattered over the trunk and limbs, and it was in all respects like chicken-pox. The spots on drying up pre-

sented little scabs, but had no tendency to ulcerate. Some which had been scratched showed blood crusts. I felt justified in giving a very confident opinion that the eruption was only a recurring varicella, and that it had nothing whatever to do with syphilis.

The sequel quite confirmed this diagnosis. After a time the child got quite well under non-specific treatment. It remains so, I believe, at the present date (two years later).

An unusual point in the history of this case was that an interval of some length was said to have occurred between the original chicken-pox and the recurrence. During this period the child was said to have been quite clear. The liability to recurrence and persistence of chicken-pox is well known. I have entered pretty fully into the consideration of the subject on a former occasion.*

No. LXII.—*Herpes After-pain—Its severity and prolonged duration in the aged.*

All will agree, I think, in the opinion that the severity and duration of herpes after-pains are usually in ratio with the age of the patient. Young persons do not suffer from after-pain from shingles. In old people the pain may last for years. Of this the following case is, amongst many others, a good example.

Mrs. S——, an old lady of 70, suffered from herpes zoster a year ago. She avers that she is still never free night or day from a distressing aching pain in the parts which were affected (ear, neck, and shoulder). The pain does not now shoot and sting as it used to at first, but is rather an unbearable ache. Her nerve pains did not begin with any severity till the herpes spots were healing. This statement applies only to her skin, for the first symptoms which drew her attention to the eruption was a severe pain in the ear. She asserts that she has had earache ever since. I saw her in the first instance on June 16, 1889, at her own house, when she was just recovering from influenza. She was then in bed, and suffering so much from the herpes after-pain, that she could not

* See "Lectures on Rare Diseases of the Skin," pp. 19 and 227.

bear to be examined, and could scarcely speak to me. Since that she has visited me several times. She is a cheerful person, inclined to make the best of things, and she has now regained very fair health, but her complaints about the pain are incessant, and she will sit and weep during her visit to me. She says that it entirely prevents sleep at nights, and compares it to a gimlet boring into the ear. From the ear it passes down to the clavicle and tip of shoulder.

This is perhaps the most severe case that I have seen, but I have observed not a few which closely approach it. I have known several in which herpetic after-pains made the remainder of the patient's life a state of misery. They were all in old persons. Quinine and aconite are the most useful remedies, but I have had no triumphs.

No. LXIII.—*Pregnancy a cause of Pruriginous condition of Skin.*

Amongst the constitutional conditions which may cause a general pruriginous susceptibility of the skin we must rank pregnancy. That this state may be attended by what is called prurigo of the genitals has long been recognized, but I do not think that attention has been sufficiently given to its possible influence on the integument as a whole. I will narrate a single illustrative case. A lady who has borne several children tells me that always, during the last three months of her pregnancies, she has suffered from intense irritation of her skin over the whole body and limbs. Nothing that her medical adviser could do ever gave her any relief, but the trouble disappeared immediately after her confinement. There was no eruption until she scratched, and by scratching she often produced wheals, or even sores. Some years after her last confinement she was under my care for pruriginous eczema of the hands (a sago-grain eczema, allied to cheiro-pompholyx); and some years later still, having had her hands quite cured, she had burning irritation on the top of her head, attended (after scratching) by a slight eczematous condition.

No. LXIV.—*On Lupus Necrogenicus, and the stage at which Gland Infection occurs—Its distinction from Lupus Vulgaris.*

That the infective stage in cases of lupus is far more active in the very beginning than it is later on, is well illustrated in cases of necrogenic lupus on the hand.

The following case illustrating this statement was brought to me by my son.

A middle-aged and somewhat delicate-looking woman had large glandular swellings in her left axilla and just above her elbow. They were clearly in connection with a small patch on the back of her hand, which had all the characters of necrogenic lupus, and which she attributed to having pricked her hand while stitching a skin-rug. The skin at which she was at work was dry, and, beyond the fact that it was animal matter, there did not appear any reason for supposing that it contained any virus.

The woman was engaged in cooking, and might easily have scratched her hand on a bone. Whatever the source of irritation had been, the patch was, however, quite characteristic, and was exactly like what we so frequently see on the hands of medical students. It was about the size of a shilling, and not itself inflamed or ulcerated. It was somewhat thickened, and had in the middle a closely adherent crust which could not have been removed without making it bleed. Taken in conjunction with the swelling of the glands, it had given rise to the suspicion that it might be a primary specific sore; neither my son nor I had, however, any hesitation in putting aside this suggestion, for there were no constitutional symptoms, and the glandular swellings were acute and threatening abscesses. Her condition was, in fact, exactly what I had myself passed through in student life in connection with post-mortem pricks.

I advised that the patch on the back of the hand should be promptly destroyed by the acid nitrate, and that the threatened abscesses in the glands should be repressed by evaporating lotions if possible, but opened, as early as might be, should suppuration occur.

It may be convenient here to discuss the question as to whether these patches of so-called necrogenic lupus are due to the introduction of tuberculous matter, or to any other form of particulate virus. That they occur to dissectors and to cooks, and that they are in connection with scratches and pricks whilst dealing with animal matter, is, I think, beyond any question. That they occur to cooks as well as to medical men is a conclusive fact in disproof of their being in any way connected with the syphilitic virus. Undoubtedly cases of common lupus on the hands and feet not unfrequently exhibit conditions which it is difficult to distinguish from the necrogenic form. Still, however, I think that there are differences which should be recognized. Thus lupus vulgaris scarcely ever causes glandular enlargements, whereas implication of the glands and the formation of more or less acute abscesses are exceedingly common, indeed almost the rule, in these necrogenic sores on the hands. On the other hand, the necrogenic sore, after the first stage of more or less acute gland-implication is passed, exhibits far less tendency to serpiginous spreading than does lupus vulgaris.

My own personal experience in this matter has been so instructive that I may perhaps be pardoned for relating it. In my student days I got, of course, many needle-pricks, bone-scratches, &c. on my hands, and on the knuckles of my left hand three distinct patches of necrogenic lupus formed almost simultaneously. It may have been that they were all from scratches from the same subject, but about this I cannot tell. I was at the time constantly engaged in dissection and post-mortems. I do not remember much about the very earliest stage of the sores, but certainly they were never attended by any indications of acute infection. Sub-acute glandular enlargements promptly occurred above the elbow and in the arm-pit. Large chronic abscesses resulted, which, having been opened, the sinuses left were slow to heal.

In both situations I well remember that incisions had to be made several times. I was much out of health at the time, and had to desist from work on account of the abscesses for at least four months. No one at the time advised any radical treatment for the original sores, but some years later when

they had passed into a quite chronic condition I repeatedly applied the caustic acid nitrate of mercury. By this means two of the patches were completely cured, a thin inconspicuous cicatrix alone remaining. I have now to ask attention to a fact which is, I think, really remarkable in reference to pathological laws. The treatment being inconvenient inasmuch as it disabled my hands, I desisted from it as already said, leaving one patch only partially cured. During nearly forty-five years that patch has remained with but little change. It is still in a quite characteristic condition of thickening with a closely adherent epidermic crust. In summer it gets almost well, and in winter, in accordance with the general law as regards lupus, especially when on the extremities, it usually inflames more or less. There has never been the slightest tendency to irritation of the glands since the first occurrence of abscesses, nor has there been any production of satellites nor any serpiginous spreading of the patch.

These facts, I think, conclusively show that there is something in the necrogenic lupus which stamps it as distinct from vulgaris. Yet I believe that the tubercle bacillus has been found as frequently in connection with the one as with the other.

That the irritating material which produces the necrogenic patch is of the nature of tubercle seems to me exceedingly doubtful. I am much more inclined to associate it with the virus which occasionally causes acute blood-poisoning, preceded by lymphatic inflammation. From this latter it appears to me to differ only in degree of virulence.

No case can, I think, better illustrate the importance of vigorous local treatment than my own. The patches which were thoroughly destroyed have remained perfectly well, whilst that which was not so treated has well illustrated the power of local persistence of a form of chronic inflammation through a long series of years.

No. LXV.—*Note on the Diagnosis between Erythematous Acne and Lupus Erythematosus.*

Although the bat's-wing form of eruptions on the face is

very characteristic of lupus erythematosus, yet we must by no means trust to it for differential diagnosis. Other eruptions may produce very similar appearances. I have just seen two patients whose faces illustrate this remark ; in one of them the disease being really a form of acne rosacea, in the other a dry eczema, due to exposure. In the first of these cases the patient, a gentleman of thirty-one, had been told that he had been the subject of lupus erythematosus, and as such was sent to me by a very able dermatologist. I will state my reasons for dissenting from this opinion. The condition was one of diffuse redness of the whole nose, especially of its tip, and it extended on each side quite symmetrically upon the middle of the cheeks. The erythematous patches were, however, ill-margined, and on the cheeks were attended by that condition of dilated capillaries which is so aptly compared to red sea-weed. These sea-weedy dilatations were to be seen on other parts of the face, and nowhere were there erythematous areas with well-defined and aggressive edges. On looking critically at his nose it was seen to be spotted all over with little comedones, and the plugs of sebaceous matter were squeezed out with great ease, being rather softer than usual. Now true lupus erythematosus, when attended with comedones, usually assumes the dried orange-peel condition ; and the plugs of sebum cannot be ejected without much trouble. Taking this feature of marked difference into consideration, and with it the fact that the erythema was never circumscribed, I feel justified in claiming the case as one of diffuse rosaceous acne, and not lupus.

No. LXVI.—*A form of Psoriasis which was not attended by desquamation, and which left scars—Easily cured for a time by arsenic, but persistently relapsing for forty years.*

A gentleman, now aged about 64, has been for more than forty years the subject of "psoriasis." He has been under almost all the English dermatologists and several of the continental ones, and those who gave it a name always said "psoriasis." He has taken much arsenic, and has always

found himself better for it, the eruption having often been cured in the most definite manner by it. Yet the eruption presents some curious features of distinction from common psoriasis. When he came to me he had only a few patches in the middle of the back. I noticed that they were irregular in shape as if serpiginous, and that they were leaving scars. On mentioning this, Mr. — at once said, "Oh yes, it always leaves scars; they wear out after a time, but at first there are always slight scars." I noticed also that the scale crust was very thin and firmly adherent, and asked whether at any time when the eruption was copiously out he had been troubled by the shedding of scales into his bed. "Never a scale," was his reply. Here, then, we have a "psoriasis" which never sheds scales and which leaves scars. Another feature of difference I have yet to mention, and it is this, that Mr. — assured me that when the eruption relapsed it never came to the old places, but always to new ones. It did not appear to have ever been definitely symmetrical, and had not specially affected the elbows and knees.

It may be thought that this eruption more nearly resembled a multiple lupus than true psoriasis; but, in reply, I must assert however that it had always yielded most definitely to arsenic, and that it had never visibly ulcerated, and that the scars left were of the most trivial character. Probably it is a hybrid between psoriasis and lupus, but partaking more of the characters of the former than of the latter.

No. LXVII.—*Eczema Marginatum on one leg subsequent to a similar affection of the Groins, &c.*
—*Residence in the Tropics.*

A married gentleman, aged 36, under my care in 1891, showed a most remarkable example of eczema marginatum. His left leg was almost covered from ankle to knee by one immense patch. Its borders were as abrupt as possible, but there were in many places little satellite patches, and minute pustules near to them. I was told that the chief mode of spreading was by satellites, which coalesced; but I doubted

this, for its slightly raised border had all the appearance of a serpiginous progress. The general surface of the area involved was smooth, of a red plum-colour. The edge was slightly scaly and a little raised. I took some scales from the latter for microscopic examination. He had a small patch of quite recent formation in the right crutch. Mr. T——'s history was that the patch, as I saw it, and as it is displayed in a portrait then taken for the College of Surgeons, had been present only eight months, but he had suffered from the same disease on several former occasions. He had lived much abroad, and it had repeatedly relapsed in hot climates. It had always been called "*eczema marginatum*," and he had been cured on one occasion by Goa powder, and on another by Harrogate water baths. All his life he had, indeed, been subject to occasional skin irritation. Even as a boy, if he perspired much, spots of *lichen marginatum* would appear on his chest, and if he took port wine it invariably brought out erythematous and very irritable patches of what he called psoriasis, but which never lasted long. He did not think that he had ever in his life had pityriasis versicolor or true ringworm. He was of gouty family.

The *eczema marginatum* developed for the first time in 1881, and affected the skin of the thighs in contact with the scrotum. It was very bad, and took a long time to cure. From 1881 to 1885 he resided in England, and was almost free. In 1885, and from that to 1887, he was again attacked whilst again residing in the tropics. On this occasion he had patches on the left leg and right thigh. From June to October, 1888, he was at Harrogate, using the baths, and at length got well.

It is interesting to note in reference to the difficulty of transferring a malady concerning which we could not doubt that it spread by contagion in the part affected, that Mr. T—— had never infected his wife, nor had patches developed on the other leg, although, of course, constantly in contact with the affected one.

After prolonged examination, neither my son nor myself could find any trace of fungus in the scales which were scraped from the patches.

A portrait of the leg was taken by Burgess for College of Surgeons, November, 1891.

Another trial of Harrogate and of various local applications has not succeeded in wholly curing the disease.

The points in the case are—1st, the probability that the eruption was of cryptogamic causation in the first instance; 2ndly, the absence of fungus now; and, 3rdly, the very definite influence of hot climates in causing relapses.

No. LXVIII.—*Alopecia after Ringworm.*

Mr. H—— brought me one of his sons, a cadet of eighteen years of age, who had three patches of alopecia areata on different parts of his scalp. They presented all the usual characters. I asked as to ringworm, and was told that the patient and a brother of his had suffered from it six years ago. In the patient there had been only a single patch so far as had been observed. It had lasted, however, a considerable time. The part which Mr. H—— believed to have been originally the site of the ringworm was not affected by any one of the alopecia patches, but there was one near to it.

No. LXIX.—*An Elementary form of Kaposi's Disease.*

Two girls, sisters, the Misses McC——, one aged 14 and the other 13, were brought to me on account of a peculiar condition of the face, which was, I think, a minor form of Kaposi's disease. In the first place, both of them were very much freckled, the upper part of the face in each, eyelids, forehead, &c., being covered with brown patches. It was winter when I saw them, and I was told that these freckles became much more conspicuous in summer. In addition to the freckles, both were liable to have the skin become rough in patches on the face with the development of very minute lichenoid spots. The elder sister had been liable from infancy to a slight form of intertrigo. With this exception the limbs of both the sisters were exempt. Both the girls were in excellent health with the exception that the younger one was liable to bilious

attacks. It will be seen that there had been no evidence of a tendency to ulcerate or inflame in either of the cases. In degree of severity the disease was far below what we witness in the marked examples of Kaposi's malady. In the essential feature, however, of remarkable proneness to freckle, and of development of similar conditions in more than one member of the same family, the disease coincides with that affection.

ON CANCER.

(Continued from Vol. III., page 342.)

Infective Senile Freckles in association with Malignant (Epithelial) Growths—Three cases—Comments.

Every one must have noticed how remarkably cases which illustrate new views multiply as soon as their peculiar features have been recognized. I have just had an instance of this reference to the infective freckles of elderly persons which I have recently described, and have associated with tendency to malignant growth. During one week two new examples of this association have come under my observation, and in neither case was the patient sent to me because I had written on it. More recently still a third case has come under notice, but in it there is as yet only melanotic staining without any ulceration. These three cases may be briefly recorded as follows:

CASE I.—Dr. G—— is now 73. He has on the bridge of his nose a considerable area of coal-black staining, the margins of which are irregular and are evidently extending. On the eyelids of both sides are some indefinite black freckles. The condition, however, of most importance is a papillary patch on the right cheek about as big as a sixpence, and evidently an early stage of epithelial cancer. It is quite black, but being rough and warty it is difficult to be sure that it is really pigmented. Dr. G—— is in excellent health. He has known of the freckles on the nose for six years or more, and of the malignant patch on cheek for nearly two. I take his case to be another example of the association of epithelial cancer with pseudo-melanotic staining, of which I have recorded examples in Vol. II. p. 85, and Vol. III. p. 321.

CASE II.—In my next case the patient is much younger. She

had herself applied the term "freckles" to her black patches, although, so far as she remembered, she had not in youth been liable to freckle. Mrs. P. T—— is only 39 years of age, but is more senile than her years denote. She is the subject of acne on her chin, and of acne-prurigo over the whole face. She has also suffered from nettlerash. She has on her right cheek a black patch as large as a shilling, which she says began as a freckle five years ago. It is now distinctly papillary in the middle, and is both spreading and growing. She denies having ever had any mole on the affected part. I have no doubt that the "freckle" is passing into epithelial cancer, and have insisted on the importance of its complete destruction.

CASE III.—Mrs. S——, an old lady of 71, who has enjoyed excellent health through life, now suffers from chronic rheumatism. She has a conspicuous black patch on her right cheek, and near to it some smaller ones. There are some of a less well-marked character on the other cheek, and one or two florid nævi.

It has so happened that in all the cases which I have yet seen of this infective senile melanotic staining, it has been the right cheek which was chiefly affected. This is contrary to what occurs in xanthelasma of the eyelids, in which almost invariably the left side takes precedence.*

To these cases I am able to append another which illustrates the same sequence of events—melanotic staining of tissue long preceding malignant growth. The part affected was, however, not a senile freckle, but the mucous membrane of the mouth in a patient not past middle age.

Black Pigment-staining of Gums and Cheek, preceding by a long series of years the development of Malignant Growths in the Gums.

Mr. Willett was good enough to give me an opportunity (May, 1891) for examining a very important example of this

* Should any of my readers have opportunities for inspecting the cheeks of aged persons and observe the black stains to which I refer, I shall be much obliged by information as to which side the patches chiefly occur on. My impression is that in slight forms the condition is not uncommon.

state of things in a case which was under his care in St. Bartholomew's Hospital. The patient was a woman of about forty. Black patches had been gradually spreading on the gums and cheek of her left upper jaw and buccal pouch, for more than fifteen years. She attributed the first appearance of staining to the irritation of a tooth plate. For long there had been nothing but coal-black staining without any thickening, but of late (the last two years or so) the gums had shown tendency to fungate. A portion of diseased gum had been cut away at the Croydon Hospital six months ago, but the growth had recurred, and for this she now sought Mr. Willett's aid. The gum presented an irregular outgrowth which had an uneven surface with small polypoid projections. The growths were everywhere coal-black. It was ulcerated where the teeth had been, but presented a quiet condition, and was not unhealthy. On the adjacent parts of the cheek and lips there were large conspicuous patches of coal-black staining. This resembled the colour in mouths of dogs, only much blacker, and arranged quite irregularly. It was not attended by the slightest thickening.

Mr. Willett cut away the diseased gum on May 18th, and removed at the same time as much as could be taken of the stained mucous membrane. It should be stated that no enlarged glands could be found. Mr. Willett will probably record the case in detail with microscopic examination, and it will be of much interest to know whether the new growth is to rank as sarcoma or epithelioma. My interest in the case is chiefly in that it affords another example of a change which may be counted as little more than physiological aberration existing for a long series of years with infective spreading, and ending at last in the local production of malignant growth.

Unusually long interval between Excision of Cancer of the Tongue and implication of the Glands.

I have had recently two remarkable cases in which the interval between the excision of a cancerous sore on the tongue and the development of gland disease was unusually

prolonged. As a rule in epithelial cancer, if after a successful operation, so far as the primary disease is concerned, the glands do not enlarge quickly, they will not enlarge at all. After the expiration of six months from the date of the operation, I have usually felt tolerably confident that the disease would not return. In each of the two cases to which I have now to refer, however, the first manifestation of gland disease has occurred after an interval of twenty months, during the whole of which the scar of the operation has remained perfectly sound, and there has been not the slightest trace of lymphatic engorgement. Such a result has been, I repeat, in my practice very exceptional. In both of the cases the excision was done at a very early stage of the disease. In one the cancerous ulcer was not so big as a sixpence and quite superficial, and confident opinions had been expressed that it was not cancerous at all. I removed it, however, very freely, according to my invariable rule in such cases, which is to operate, if possible, in the precancerous stage of cancer. The microscope proved, however, that the little ulcer really was malignant, and, as stated above, the glands have confirmed this verdict by taking on enlargement twenty months after operation. In this case the patient is an elderly gentleman, a distinguished author, of more than seventy years of age. In my second case my patient is a lady under forty, who showed me a suspicious sore on her tongue, which was attributed to the scratching of a tooth. I advised and performed an immediate excision of about a third of the organ. It healed well; she had no trace of gland enlargement when the operation was done, nor did any occur till rather more than twenty months afterwards, when she came to me with the tongue perfectly sound, but a mass of enlarged glands under the upper third of the sterno-mastoid. In each of these cases at the time that I saw the patient for the recurrence of the disease in the glands, the circumstances were such as to discourage me from further operation. The enlarged glands were placed under the upper third of the sterno-mastoid, and there were several of them. In such cases I have never found that an operation was of real advantage to the patient.

Epithelial Cancer at Early Ages.

In 1889 I operated upon a brother and sister for epithelioma at somewhat unusually early ages. The brother was forty-two years of age, and the sister only thirty-four. In the brother the growth was in the hard palate, and in the sister in the right labrinum majus. In both the microscope confirmed the diagnosis. Both were quite well two years afterwards, and, so far as I know, are so at present. The only family history forthcoming in this instance was that a great-aunt had died of cancer of the breast.

Resorcin in the treatment of Rodent Cancer.

A gentleman who was the subject of a superficial and small rodent ulcer on his nose had been treated by me repeatedly by applications of the acid nitrate of mercury. Temporary cures were obtained, but in six or eight months he usually returned, requiring another use of the caustic. He has been good enough to write to me from India to let me know that a complete cure has, he thinks, been obtained by the employment of a resorcin ointment, 20 to 40 per cent.

A Quiet Bronchocele becoming Malignant.

The transition from non-malignant growth or even from hypertrophy is, I believe, not unfrequently witnessed in the case of the thyroid gland. An instance of this I find recorded by the late Mr. Dulfon, of Birmingham.* A woman of sixty had been the subject of quiet bronchocele from girlhood. It had caused her no inconvenience until three months before she came under Mr. Dulfon's notice. It then became very hard and increased rapidly in size. The increase was chiefly on the left side. Both trachea and œsophagus became compressed, and she was unable either to swallow or to lie down. Death from asphyxia followed in about five months from the beginning of the enlargement. The tumour on examination presented "a soft pulpy mass of a medullary character throughout." The late Mr. Hodgson, who spoke in the discussion, said that he had seen an exactly similar case in a man.

* Birmingham Pathological Society, Oct. 5, 1844.

RHEUMATISM AND GOUT.

No. XVII.—*Anchylosing Rheumatism and Spondylitis Deformans—Antecedent Gonorrhœa and Stricture.*

A remarkable example of this was shown to me in the Lambeth Infirmary by Dr. Lloyd (Oct. 13, 1891). The patient, a rather florid man, aged 54, had suffered for twenty years, and was almost literally one piece of bone. Knees, ankles, and hips were quite stiff, and so were his elbows, shoulders, and wrists. The last-mentioned joints were still somewhat swollen, and not absolutely ankylosed. His hands and feet were distorted, and all his digits bent into the palm. His hands lay on his chest, and he could not lift them. His lower jaw was ankylosed, but he could still eat when food was put into his mouth. He had formerly been in better circumstances, a traveller, I think, and he attributed his attack to his having been put into a damp bed. He had never had acute rheumatism, and his symptoms had developed very gradually. For a long time he helped himself about with sticks, then for six years he went about on crutches, then for eight in a bath-chair, and finally he has been for seven bedridden in the Infirmary. He said that he was never free from aching pain. He has been for many years the subject of stricture, and had had gonorrhœa before the rheumatism set in. As regards family history, it is not known that any of his relatives have ever suffered from either gout or rheumatism. The whole of the spinal column, with the exception of the neck, appears to be stiff.

I attach great importance to the history of gonorrhœa and gleet as predisponents in this case. It is further very possible that the patient does not know his family history in reference to gout.

No. XVIII.—*Neuritis in one eye only with gout, in a woman—Retinal hæmorrhages in the other.*

A woman, aged 37 (Amy N——), had experienced several attacks of gout in her toe, one of them a severe one. She was a liberal beer-drinker. Her paternal grandfather had suffered from gout. When she came under my care, she had been for a year nearly blind in her left eye, and the disc showed atrophy and great diminution of vessels. In the other eye were recent hæmorrhages into the vitreous and retina. There were casts in the urine, but no albumen.

No. XIX.—*Ulceration of Legs—Hydrops Articulorum affecting symmetrically the Wrists and Ankle, and in association with congenital looseness of joints.*

This lady had been born in India, but had been brought to England in childhood. She did not know much as to what maladies had occurred in her family in previous generations, but there was a tradition that one at least of her relatives had suffered from gout. One fact was quite certain, that in several generations a very remarkable laxity of most of the joints had been noticed. Thus she could herself throw her first phalanges backwards on the metacarpal bones almost to a right angle, and most of the phalangeal joints admitted of some lateral movement, and all felt loose. She could make her elbows touch behind her back without much effort, and she believed that she shared these peculiarities with several relatives. One of her own children, she said, had joints just like hers.

Mrs. ——— was sent to me on account of “a peculiar form of swelling in the neighbourhood of several joints.” Dr. Bain Sincock, of Bridgwater, who sent her to me, informed me that he had opened one on the wrist, thinking it might be a ganglion, but had found that it could not be removed. On first sight of the wrists I made no doubt that she was the subject of ganglia, one on each side, at the back of the wrist, but further examination induced me to alter this opinion and to think that the swellings were bulgings of the synovial mem-

brane. The principal swelling was placed lengthways at the back of each wrist on the ulnar side, and was two inches long and fluctuated freely. The extensor tendons were little if at all lifted, but on the radial side there was another swelling less elongated but broader than the first. On the front of the wrist there was no perceptible swelling, but pressure on those of the back convinced me that a certain degree of fulness could be produced in front.

I had no hesitation in believing that the two swellings on the back of the wrist communicated under the extensor tendons. The ganglion-like swellings were quite flaccid when the hand was straight, and became tight when it was bent backwards. The whole wrist was very loose, the bones could be moved in almost any direction, the degree of movement between ulna and radius was far greater than usual, as was that also of the pisiform bone. Thus there appeared to be a general tendency to synovial effusion, but wholly without inflammation. There was not the slightest tenderness, and excepting that the wrists and fingers were weak, the patient stated that she could use her hands freely. She was still accustomed to play the piano, but complained that exercise sometimes made them ache. The amount of effusion into the left wrist was much less than that into the right.

Mrs. — had not in the first instance complained to me of her ankles, but on my inquiring whether any other joints were affected, she then told me that for many years, indeed almost from childhood, her ankles had been weak and swollen. She had formerly often fallen, from twisting her ankles. I found on examination that there were large swellings bulging beneath the malleoli on both sides in both joints. Like the swellings about the wrists, these were quite painless, unattended by the slightest thickening, and freely fluctuating. It appeared probable that the swelling had increased considerably of late, but Mrs. — was certain that it had been present in some degree for several years.

There appears no reason to doubt that we have here to deal with a case of almost passive *hydrops articuli* affecting symmetrically the wrists and the ankles—joints which are very seldom indeed the seat of that malady. There had

never at any time been effusion into the knees, nor had the patient ever suffered from acute rheumatism. She was apparently in tolerably good health, though of somewhat feeble circulation. In early life she had suffered from chilblains, but not recently. It is not improbable that the family history of remarkable laxity in the ligaments, &c., of the joints was in a not unimportant connection with this tendency to passive effusion and distension.

Although not acting as a cause, it may yet have permitted in an especial manner its formation. It may indeed have been itself an evidence and result of chronic arthritis in some predecessor, and although I must admit that the facts that were forthcoming as to family history were not strong, I yet feel little doubt that the real cause of the affection was inherited gout.

No. XX.—*A Case illustrating Peripheral Neuritis in Gout.*

A few general statements appear to be true of all forms of inflammation directly due to gout. They are all transitory, and although they may be very severe, they seldom disorganize the structures affected. Although by no means invariably so, the pain which attends them is as a rule much in excess of the other phenomena. These statements apply, I believe, to those forms of peripheral neuritis which are associated with gout. Of these, Sciatica, in some of its forms, is perhaps the most marked example. In gouty sciatica large areas of skin may become numb and painful, and groups of muscles may become weak, but the anæsthesia and the paralysis are never complete, and they both of them disappear almost wholly when recovery takes place. Although we may quote sciatica as the most striking and best known example of gouty neuritis, it is far from being the only one. Other nerve trunks or plexuses may suffer in a precisely similar way, and thus in the case of the arms we may have brachyalgia under precisely the same conditions and with parallel results. I have seen many examples of this, and many others of neuritis of smaller and isolated nerves in various parts. The anterior crural is, I believe, very rarely affected, and the case to be narrated is

almost the only example of it in a severe form which I can at present remember to have seen.

Mr. A. G. D——, a gentleman of sixty-one, of large frame, and who, although strictly temperate, had lived liberally, consulted me on January 25, 1892. It was on account of lameness and numbness in the left lower extremity, consequent on an illness which had begun five months ago. He described himself as having suffered “all the forms of torment mentioned in Foxe’s Book of Martyrs.”* His attack had begun by pain in the parts on the front of the thigh and about the knee. For this he was sent to Bath, where he rapidly got worse, and was glad to return home and keep his bed. The pain now became excruciating. It came on in paroxysms and assumed various forms. The skin of the front of thigh would burn and tingle, and sometimes felt as if pierced by a thousand red-hot needles. At other times a pain which he named “the carpenter” would come on, and which he described as like having his bones sawn or chiselled. He could not endure the slightest touch to the skin or a breath of air on it at the time the pain was on. In addition to the pain the skin felt numb. Various remedies were tried, but with very little effect, and it was not till after two months that he was able to leave his room. Whilst confined to bed he had an attack of acute gout in the great toe of the other foot, and he experienced also several severe paroxysms of difficulty in breathing and pain at the heart, one of which he believes was nearly fatal. They were relieved by inhaling nitrite of amyl, and were no doubt of the nature of angina.

Mr. D—— believed that when he left his bed the muscles in front of his thigh were quite wasted. When he came to me they had recovered to a considerable extent, but were still not nearly so good as those of the other limb. He could lift the limb and kick fairly well. At this date the tenderness of the affected areas of skin had quite disappeared, and he could bear to have it slapped or pinched, but certain parts were

* The following terms were used to describe the pains: “Burning, lancing, hot irons, ice, hot needles, electric hammers, and various others, the utmost nature could bear.”

still partially numb. There had never been any pain or numbness in the back part of the limb, nor in the leg much below the knee. A distressing sensation which still persisted was, as he described it, as if the knee were fixed in a case. The distribution of the numbness had been pretty exactly that of the external, middle and internal cutaneous nerves, but I failed to detect any evidence of implication of the long saphena.

Mr. D—— had been seen by several physicians before coming to me, and had been assured that his kidneys, heart, &c., were healthy. He said that his urine at one time had been so loaded with uric acid that it looked like a mixture of red lead. He was not aware of any history of gout in his predecessors, but in this matter his knowledge was no doubt at fault, for his eldest son had suffered from gout before he did himself, and from his statements it seemed probable that most of his children were prone to pass uric acid.

Mr. D—— could, with the help of a stick, walk fairly well at the time of his visit to me, and he was still improving. His muscles were gaining in strength, and his skin was losing the sensation of numbness. He had been carefully treated, and had been restricted to whisky and water.

A very important fact remains to be added to this history, although it is one which possibly had no close connection with what has been described. Mr. D—— had the ulnar nerve in his right arm, or at any rate its motor part, in a state of almost complete paralysis. There was a conspicuous hollow between thumb and forefinger visible behind, and the muscles of his little finger were wasted. He could use his interossei somewhat, but not well. He was well aware of this peculiarity, and it had been carefully examined by other observers. It had been developed three years ago in direct connection, as he believed, with his having carried a heavy portmanteau a considerable distance. A few days later he found the arm aching and weak, and had a "sensation of funny bone" at the elbow. He denied that there had ever been any loss of sensation in the parts supplied by the ulnar nerve, and certainly none could be proved when I saw him. If the neuritis which led to this condition were gouty, it must be

admitted that it had been almost wholly painless, and that but little restoration, as regards the muscles, had taken place. I am inclined rather to consider it as an instance of paralysis from overstrain and of the same nature as the cases recorded in ARCHIVES, Vol. III. p. 239. As regards the anterior crural, the facts seem to me conclusive. That the patient was in a gouty state at the time was undoubted, and the symptoms indicated that all branches of the nerve, with the exception of the terminal filaments of the long saphena, were affected. In explanation of the extreme pain, and especially of the tenderness of the skin, I would suggest that not improbably the end-organs were themselves implicated.

No. XXI.—*Symmetry in Hand-changes in Rheumatic Gout—Inheritance of true Gout on both sides.*

In November, 1891, Dr. Hack Tuke brought to me a lady who presented a very interesting example of symmetry in rheumatic gout. It was acro-arthritis so far as the last joint of the index and little fingers of both hands were concerned. Of these fingers, the last joint was in all more or less disorganized and the terminal phalanx somewhat displaced. In every case this last phalanx was twisted laterally towards the next finger; thus the end of the little finger pointed to the ring finger, and the end of the index towards the middle finger. In the thumbs all the joints were somewhat affected, but the stress of the disease fell on the proximal one. This latter, the carpo-metacarpal, in both hands was very much thickened, the end of the metacarpal bone being considerably enlarged. The two hands were in all respects exactly alike.

Miss H—— was a little, nervous, energetic lady of 61. She had, on the whole, enjoyed good health. She told me that both her parents had suffered from regular attacks of true gout, and that her father, who was a surgeon, had warned her that she must not take malt liquor or wine. She herself had never had an attack of true gout nor any acute attack of rheumatism. She had suffered much from neuralgic headaches in cold weather.

MISCELLANEOUS CASES.

No. LI.—*On the Spider-Nævus.*

I wish to describe a form of nævus with which I have long been familiar, but which has, I think, not as yet received much special recognition. Its peculiarity consists in that it has a distinct centre, from which branches radiate in all directions. Its centre is very small, but is so definite, and apparently so active in filling its tributaries, that it might be compared to a minute heart. The size of the nævus is rarely greater than that of a fourpenny-piece or a sixpence. The condition of branching out from the centre suggests a resemblance to the small body and the long limbs of some insects, and thus I have been in the habit of naming the whole the "spider-nævus."* If you put the finger on the middle of one of these nævi it may be completely emptied with but slight pressure, but the refilling when the finger is removed is instantaneous. The "spider-nævus" is never congenital, nor have I, so far as I can remember, ever seen it in very young children. After the age of five, however, it becomes common, and it is far more frequent in young persons than in adults. I have, however, recently destroyed a nævus of this kind, and of very well marked characters, on the temple of a gentleman of thirty-two, who held that it had been present only two years. Most of the cases which I have treated have been in young girls between the ages of seven

* I am aware that in using this name I am only reviving one which was familiar to our ancestors. They had a "Nævus aranarius." The name has, however, lapsed, and I am not acquainted with any definition which was ever applied to it. It may possibly have been used for exactly the same condition as that to which I now wish to apply it. If so, however, I have quite failed to find in the older surgical works any parallel description.

and fifteen. I have seen far fewer in boys, but this may be because the disfigurement is less thought of in them. By far the most usual position of this nævus is the tip of the nose, but it may occur on any part of the face, and they are not unfrequently multiple. I have treated many of them, mostly, I think, on the children of my professional friends. It is sufficient to destroy the centre by a light touch of nitric acid. The limbs of "the spider" will usually afterwards shrivel; if they do not do so, they also may be lightly pencilled out with the caustic. It is essential not to do too much at first, or a scar may be left more disfiguring than the original stain. The operator should bargain to be allowed to use the caustic several times if necessary rather than do too much at once. The "spider-nævus" always begins at its centre as a little red spot. It tends to grow, that is to develop longer and longer limbs, for a year or two after its commencement, but not, I think, indefinitely.

It might be of interest to speculate upon its anatomical peculiarities. I have little doubt that, although not itself usually perceptible at time of birth, it takes its origin in congenital peculiarity of structure. That its centre is in some slight degree pulsative seems highly probable. It is in the possession of this definite centre that it differs from all other forms of nævus.

No. LII.—*Nævi on the Hands.*

It is but very seldom that the extremities are affected by nævus. I have scarcely ever seen them on the feet, and but very rarely on the hands. I was myself the subject of an exception in this matter, having had from boyhood two little nævi placed symmetrically in the lower part of the palm of each hand, about two fingers' breadth above the wrist. They did not project above the level of the skin, and did not cause the slightest inconvenience, not being larger than pins' heads. They were easily emptied by pressure. As a boy, I used to amuse myself by noting how exactly they fitted, the one upon the other when the palms of the hands were placed together. I had neither nævi nor moles on other parts of the body.

PLATE LXXVIII.

LUPUS LYMPHATICUS (LYMPHANGEIOMA).

THIS portrait represents the condition of the disease in Miss D—'s case before the operation. The description of the cure will be found on p. 75. Miss D. was a young lady of 18, in excellent health. The history was that something resembling a nævus or port-wine stain had been observed in early childhood, although nothing had been noticed at birth. An excision operation for a so-called nævus had been performed by a London surgeon in childhood. Of this the scar which remained is shown in the drawing. After this operation, the little lymph-warts, which are characteristic of the disease, began to increase in number, and to extend over the upper part of the breast. Gradually the condition of things here depicted was produced. The so-called warts were vesicles with firm walls, which contained lymph-fluid. Near to them, and sometimes upon them, were numerous little tufts of dilated capillaries, which contained blood, and which could not be emptied by pressure. Some of these were almost black in tint, and others brown, like grains of cayenne pepper. The pathological process was clearly an infective one, and the disease had advanced by the production of satellites near to the original growth.

This case is a typical example of the disease to which some years ago I gave the name of *Lupus lymphaticus*, and of which a full description, one by the late Dr. Tilbury Fox, and another by myself, will be found in the Pathological Society's 'Transactions.' Dr. Fox was the first to describe its pathological anatomy. Anatomically it consists of persistently dilated capillaries and lymph-spaces, and may be named, as it has been by most dermatologists, *Lymphangeioma*. Clinically, however, it is an infective and serpiginous malady, and very prone to attacks of erysipelas. It is curable only by complete destruction of the morbid elements. The features just named appear to me to place it in close alliance with lupus, although of course constituting a separate group in that family.

Compare with Plate XVI. in Vol. I.



About the age of forty I noticed one day that one of my spots had disappeared and that the other was still there. In the course of two or three weeks, however, the second had followed, and there has never since been the slightest trace of their existence.

A gentleman named Mr. A F——, who was under my care for another matter, was the subject of a superficial nævus on his left hand. It was a sort of port-wine stain, and involved in irregular patches the palm and the palmar aspects of his thumb, index and middle fingers. It extended also in some parts to the backs of his fingers, reaching the nails, but did not implicate the latter. He had none on the other hand. He believed that they had remained through life (he was about 50) just as they were in infancy, without showing any tendency to extend.

No. LIII.—*Results of Treatment in a Case of Lymph Angeioma (Lupus Lymphaticus).*

Oct. 29, 1891.—Miss B——, for whom eighteen months ago I used the actual cautery very freely for the destruction of lupus lymphaticus on the mammary region, has returned to-day for inspection. (The condition before treatment is shown in Plate LXXVIII.) The result has been most satisfactory. The scars left are by no means conspicuous, and there has been no return of the lymph-vesicles. About half a dozen little “cayenne-pepper grains,” scattered in different parts of the affected area, are all that now remain. To these I apply the acid nitrate of mercury. Not a single vesicle can be found. She is greatly pleased with the result, for before the treatment the places had been liable to excoriate and bleed, besides being a great disfigurement. I have preserved an excellent portrait showing the original condition. After the free use of the actual cautery under æther, I repeatedly, during the next six weeks, applied the acid nitrate of mercury to spots which recurred. There seemed to be for a time a strong tendency to reproduction of the lymph-vesicles.

No. LIV.—*On Gynæcomazia in reference to the development of the Testicles—Atrophy of the Testes and overgrowth of the Breasts as a consequence of injury to the Head.*

Since my recent reference * to this subject, I have found in the Transactions of the British Medical Association the description of a case confirmatory of what was advanced as to the correlation in nutrition and growth between the testes and the mammary glands. A man who had served with the British Legion in Spain, and who was fifty-five years of age at the date of the observation, had pendulous and very large mammary glands, with entire atrophy of one testis and partial of the other. His voice was weak, beard thin and soft, penis small and shrivelled, and sexual desire entirely absent. These conditions had followed, as was supposed, and in conjunction with partial right hemiplegia, as the consequences of a severe blow on the occiput received in a fall. This blow rendered him insensible, and he was for some time under the treatment of Mr. R. Alcock (now Sir Rutherford) in a Military Hospital. Previously to his entering the army he was a married man and had three children, but from the date of the accident all sexual desire was lost, and the changes in the testes and mammæ set in. Unfortunately the report before me does not give dates, but as it is said that his youngest child would have been eight years of age, we may assume that the changes had occurred within that period. It is necessary, in reference to such a narrative as this, to exercise a little caution. All depends upon the man's testimony, and he may have been desirous to conceal the real facts and to attribute to the accident that which had really been present from his youth. Arrests of the sexual functions are probably common enough after blows on the head, but I am not aware of any other facts in support of the belief that they are associated with atrophy of the testes or with tendency to gynæcomazia. There is, however, no intrinsic improbability in such consequences.

* See ARCHIVES, Vol. III. p. 327.

No. LV.—*Notes on Quinsy.*

Is there any connection between quinsy and gout, or between quinsy and rheumatism? Perhaps the latter is a more likely association. A lady who was liable to attacks of mixed rheumatism and gout, and who was also liable to quinsies, told me that she thought she usually had a quinsy just before her attack of rheumatism. My coachman, who has suffered from severe and definite attacks of gout in the great toe, is liable also to quinsies, but we have not observed any especial association between the two. The clinical history of quinsy is worthy of more attentive study than it has yet received. It is usually a very definite malady differing entirely from all other forms of sore throat. It does not occur in conditions of debility, but to robust and healthy persons, and it is not, I think, associated specially with large tonsils. Only some persons are liable to quinsy, and those who are so have repeated attacks, each one just like the other, and usually with very long intervals between them. In the case of my coachman, above referred to, an interval of ten years of entire immunity had occurred. He has just passed through a very severe attack with an abscess in each tonsil, and such swelling as for a time almost blocked the throat. I believe that quinsy rarely begins simultaneously on the two sides, but that it rarely fails of being symmetrical in the end. One tonsil takes the start, and the other usually follows after a few days or a week. This was very definite in the case of my coachman, in whom I have just been studying the phenomena of the disease. He came to me first with a very hard swelling just above his left tonsil, and without the slightest affection of the other, and it was not until the first was on the point of breaking that the other tonsil followed in an exactly similar course. Acute and well-marked attacks of quinsy pass through definite stages, and subside completely after the abscess has given way or been opened, leaving no chronic disease behind. It is very important to seize the right time for incisions in quinsy. They ought not to be made until the abscess is ripe, and they then give wonderful relief to the patient.

No. LVI.—*A Rare form of Idosyncrasy.*

A curious and interesting example of idosyncrasy came under my notice in the person of Mr. A. P——, M.P. This gentleman told me that he had had many alarming attacks of sickness and pain in the abdomen, attended by swelling of the tongue and lips, and lividity of the face. On some occasions these attacks had been so severe as to cause great alarm to his friends. For long he had been quite baffled in his attempts to find out their cause. At one time he had suspected that it was fish-eating, and especially partaking of salmon. He found, however, that he could often take fish of all kinds with impunity. At length it became clear that it was parsley which did it. Subsequent experiments convinced Mr. P—— that the smallest fragment of parsley in any state, when fresh or dry, and whether in the form of sauce or otherwise, was adequate to produce an attack. He had of course ever since this discovery carefully avoided parsley. On one or two occasions, having taken it inadvertently in soup, his old symptoms had been produced. Mr. P——'s idosyncrasies did not end with parsley. He could not take the smallest quantity of honey, and certain kinds of fruit more especially always poisoned him. The symptoms resulting from these articles were similar to those from parsley, but not usually so severe.

No. LVII.—*Mr. Berry's Lectures on Bronchocele —Influence of Drinking-water, of Heredity, and of Sea-air.*

The researches as to the causes of Endemic Bronchocele, the results of which Mr. Berry recorded in his valuable lectures delivered a year ago at the College of Surgeons, have led him to the conclusion that the old theory is well founded which associated the disease with the use of drinking-water from certain special geological formations. From his own inquiries in the English area, and from those of Virchow in that of Switzerland, Mr. Berry thinks that it is shown to be highly probable that water derived from the magnesian limestone

is especially dangerous. He declines to believe that the air of mountain valleys has any influence in causing bronchocele, or that sea-air has any power in preventing it. He also refuses to accept hereditary transmission of tendency as an important factor, or even denies its influence.

I listened to Mr. Berry's lectures with great interest. They were the result of much original work and extensive investigation. I am bound to say, however, that I was not convinced on the last two points above mentioned. I still believe that bronchocele is hereditary, and that the air of the sea-coast is valuable both for prevention and cure. It is not sufficient to show (as Mr. Berry undoubtedly did) that cases may now and then occur at the seaside. Such are, I believe, very exceptional to the general rule.

No. LVIII.—*Benefits accruing from Erysipelas.*

My colleague, Dr. Warner, brought to me five years ago a lady with a tumour of doubtful nature in one breast. It was very definite, and my only doubt was whether it was adenoma or scirrhus. We decided to wait a month or two and watch it. Our patient went home, and not long afterwards suffered a severe attack of erysipelas, in which she very nearly lost her life. When she recovered the tumour was gone. I have attended this lady again for another ailment recently, and there is no sign of any return of her tumour.

An elderly surgeon consulted me on account of nasal polypi of some size, and high up in the nostril. They gave him great annoyance from obstruction, and we made an appointment for their removal. Meanwhile he fell ill with facial erysipelas, and had a severe illness. On his recovery he wrote to me in great delight that the obstruction in his nose had wholly disappeared. I believe that it never returned. He is not now living.

The benefits which accrue to lupus vulgaris from attacks of erysipelas are matters of general and frequent observation.

Brodie has the curious observation that syphilis will disappear upon an attack of erysipelas coming on.

It appears to me that facts such as the above favour to some

extent the creed that illnesses attended by fever and high temperatures may be prejudicial to the vitality of neoplasms and cause them to wither. The local effects of Koch's treatment, when good reaction was obtained, were not dissimilar from mild erysipelas, and it seems possible that their beneficial results may have been due simply to the febrile disturbance evoked.

No. LIX.—*Maternal impressions and family tendency to defects in development.*

Two sisters have each borne a son who has defective development of one hand. In one, the ulnar fingers are absent,* and the middle and forefinger are webbed. In the other, the hand is absent by wrist-amputation in utero.

Both mothers are emotional, and highly educated; both attribute the occurrence to a maternal impression in early pregnancy. In one, a beggar showed his stump, and in the other, a man, who had had his fingers amputated, insisted on describing his operation and in showing his hand. No defects are known in other members of the family. It is, I need scarcely say, impossible that maternal impressions should produce such results. They are, no doubt, to be attributed to family inheritance, although their previous occurrence is not known.

No. LX.—*Variola as a cause of Blindness.*

The proportion of the blind in Ireland was, to the total population in 1851, one in 864, and in 1881, one in 847. Blindness was ascribed to smallpox in 725 cases in 1861, and only to 359 in 1881; a ratio to the total number of blind of one in 9·5 in 1851, and only one in 17 in 1881.

No. LXI.—*Estimation of Arsenic in the last century.*

Pomet,† in his "History of Drugs," 1748, says of the various compounds of arsenic then known, "All these kinds

* Absence of the ulnar fingers is, I believe, exceedingly rare (see Vol. III., 304).

† He was chief druggist to Louis XIV.

are very powerful poisons and ought never to be thought of as internal medicines, though some have been so daring as to prescribe them " (p. 143).

No. LXII.—*Congenital Absence of Gall-bladder.*

In the Medical Transactions of the College of Physicians is the report of a case in which an infant lived five weeks having no gall-bladder and total obstruction of the ductus communis. The infant was jaundiced throughout, and had constant vomiting, white stools, deep-tinted urine. It died at last in convulsions.

No. LXIII.—*Associated Reflexes.*

"I cannot laugh without crying at the same time, and this makes other people laugh without crying."

A sea captain said this to me. He appeared to be in fairly good health, and there was no obvious explanation of this curiously exaggerated susceptibility of certain reflexes which are normally in some degree of association.

No. LXIV.—*On Diffuse and General Eczematous Dermatitis.*

In writing about the epidemic prevalence of diffuse eczema in workhouses, to which Dr. Savill and Dr. Lunn last summer drew attention, I have always contended that we had no new disease. The opinion which I expressed, as to the cases being examples of what is well known in the history of the senile forms of eczema, has received remarkable confirmation from the fact that several of Dr. Savill's last year's patients have returned to him again this summer with a recurrence of the malady. This is exactly in conformity with what we so often observe in the eczema of elderly persons. It is a disease which spreads by contagion, but which yet takes its origin, to a large extent, in the constitutional proclivities of the individual. Not a few of the workhouse cases of last year's epidemics had been sufferers from local eczema before.

The following narrative affords a remarkable illustration of

these statements. I have already published the case some years ago as an example of locally restricted dermatitis. I now give the sequel—an attack, after many years of local liability, of most acute general dermatitis. This final attack was exactly like the worst of the workhouse cases, and neither it nor they could be well separated from many others which have been allowed to rank as pityriasis rubra. Although I have previously published the portrait, yet for the reader's convenience I again give it.

I visited Mrs. L—— at her own house, and in consultation with Dr. Chitty, on Dec. 16, 1891. She was then suffering from a most severe outbreak of acute and universal dermatitis. It was of little more than a week's duration, but the epidermis was already peeling almost everywhere. The desquamation on her face and upper part of trunk was in thin small flakes, but on the extremities it was in large paper-like portions. On the hands it was stiff and coherent, like portions of a glove. The palms were denuded, but the digits were still covered by a detached shell which adhered only at their extremities. The nails were not as yet affected in any way, and were smooth and polished. The feet were affected in a similar manner to the hands, but not quite so severely. Everywhere the skin was of a vivid red, and in some places sore and cracked, but it was not weeping anywhere. Mrs. L—— had a dry tongue, and complained much of the general dryness of her mouth. Her pulse was sharp and somewhat hard, but her temperatures were normal.

I was told that the present attack was exactly like the one through which she had passed in 1888, and not more severe. I obtained from Dr. Chitty and herself a detailed account of the commencement of the attack. Before giving it, it may be well to state that during the last few years Mrs. L—— had been constantly using tar-wash for patches of intertrigo, &c., of which she had never been quite able to get rid. These had been present chiefly under the breasts, but she had always suffered constantly from more or less of pityriasis of the scalp. Whenever out of health, she had fissures occur at the corners of her mouth. Her hands and the skin generally, that is with the exceptions mentioned, had for long

been perfectly sound. She had enjoyed on the whole pretty good health, but had been indisposed to take exercise, and often out of spirits. She had not recognized any real threatenings of gout. During the two or three weeks immediately preceding the present outbreak, she had felt particularly dull and out of spirits, but had attributed it to the weather and time of year.

The onset of the attack was described as follows:—She was sitting in her room one evening feeling dull and miserable, when quite suddenly a chilly fit came on, and she shivered till her teeth chattered. At the same time her hands felt stiff and burning, and within a few hours they became red and swollen. She went to bed, and Dr. Chitty saw her the next morning. The rigor was on Tuesday, December 8th. On Wednesday her temperature was 103, and almost the whole surface of the body was involved in erythema. On Thursday the temperature was 101, on Friday 100, Saturday 99, and on Sunday normal. During the first few days there was acute œdema of the hands, wrists, and forearms, and some also of the feet. On Friday the dermatitis was at its height, and was absolutely universal. After this, desquamation began. At one time her appearance was as if she had been scalded all over. When the desquamation began her fingers became stiff, and as if cased in parchment. She complained that they felt as if they were in tight gloves. The appetite had been very bad, but there had been neither sickness nor diarrhoea.

Dr. Chitty told me that he had often examined Mrs. L——'s urine, but had found neither sugar, albumen, nor excess of uric acid. She was of gouty family and of gouty build herself, but had lived moderately.

During the six months which have elapsed since these notes were made, Mrs. L—— has gradually improved. She has been treated chiefly with opium and antimony. She is now well, with the exception of intertrigo.

A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

No. CXXXI.—*Traumatic Tetanus.*

QUESTIONS.

1. What circumstance in the history of a case is paramount in reference to the prognosis of Traumatic Tetanus?

2. What symptom ranks next to the history as affording aid in prognosis?

3. A young man of 20 received the charge of a shot-laden gun in the inner side of his thigh. A part of his cloth trousers was carried into the wound, and being firmly fixed the surgeon, although it protruded, did not think it wise to pull it out. The accident was on Dec. 28, 1838. A lotion and subsequently a poultice were used for the wound, and all went on well until Jan. 18, when locked jaw set in. There was trismus and opisthotonos. Venesection to syncope was practised, and five grains of calomel ordered immediately, with half a grain of tartarised antimony every four hours. Venesection was repeated on the 19th, 20th, 21st and 22nd. From the last date improvement was steady, and on Feb. 8 the surgeon in charge ceased his attendance, the lad being well. During the first five days the spasms had been very troublesome, but the pulse, although hard, had never been more than 80. In addition to the measures of treatment mentioned, purgatives had been repeatedly used.

Respecting this case the following questions arise: Was the surgeon justified in leaving a foreign body in the wound? (It remained one month.) Was a cold lotion the best application for a gun-shot wound? Was the vigorous treatment pursued suitable? Was the recovery fairly attributable to the treat-

ment? What features in the case might have justified, throughout, a favourable prognosis?

ANSWERS.

1. The interval which has elapsed between the injury and the first symptoms of tetanus is the most important guide in prognosis. The longer the interval, the less severe the case.

2. The rapidity of the pulse is the chief symptom in estimating the probable severity of the case. If the pulse becomes rapid, almost from the beginning, the prospect is bad.

3. The surgeon ought certainly to have removed the foreign substance from the wound. It is even possible that the shot, wadding and portion of trousers left in the wound were the cause of the tetanus. As the wound was lacerated and contused, and must of necessity heal by granulation, the old-fashioned poultice would probably have been more appropriate than a cooling lotion. Inasmuch as the patient recovered, and as the free bleeding, &c., appeared to relieve symptoms and did not accelerate the pulse, it is impossible to censure the treatment as a whole. Since, however, there was an interval of three weeks between the injury and the first symptoms, and the patient's pulse was never more than 80, the prognosis was throughout favourable, and milder measures might have been attended with equally good results.

No. CXXXII.—*A Throat Case for Diagnosis.*

A healthy boy, two years and a half old, was admitted into hospital on account of loss of voice, hoarseness, and difficulty of breathing. He had no fever, and could at times sit up quietly and take his food without difficulty. He would even get out of bed and play about the ward. There was a history of an acute throat attack a year before for which leeches were used, since which there had always been some hoarseness but no difficulty of breathing. A week after his admission, there having occurred in the interval many attacks of most urgent suffocation, death from asphyxia occurred.*

* I have abstracted this case from a narrative by Dr. Hennis Green in the *Provincial Medical Journal*, 1842, but I have myself seen one exactly parallel with it.

QUESTIONS.

1. What is the conjectural diagnosis of the disease ?
2. What means might have established the diagnosis ?
3. What ought to have been the treatment ?

ANSWERS.

1. The persisting hoarseness and loss of voice indicated local changes, and opposed the suggestion of laryngismus stridulus. The absence of fever, the paroxysmal character of the dyspnœa, and the state of comfort in the intervals, made it certain that it was not an ordinary case of croup or diphtheria. Syphilitic affections of the larynx are almost unknown in children, and this child showed no signs of taint. There are well-known examples of papillary growths on the cords which occur in healthy children, and of these the case was probably an example. The history of a former inflammatory throat attack supports this conjecture.

2. The laryngoscope would have set the diagnosis at rest.

3. Tracheotomy was clearly indicated. After it had removed the danger of death from suffocation, treatment of the larynx might have been carried out.

[*Verification.*—At the autopsy, soft florid vegetations were found growing along the borders of the inferior chordæ. They projected into the ventricle and nearly filled it. The rima was extremely narrowed. The growths were covered by a tenacious mucus. There was no erosion or thickening of the mucous membrane of other parts of the larynx or trachea. The other organs of the body were healthy.]

No. CXXXIII.—*The Plague.*

1. What is the ratio of mortality from plague ?
2. To what circumstances do you ascribe our long-continued exemption from outbreaks in England ?

ANSWERS.

1. Fifty per cent., but it varies with the severity of the epidemic and the part of it.

2. The disease spreads by contagion only, and the conditions which favour its contagion are fortunately excluded in the more developed civilization of modern times. It is probably never communicated through the air, but requires close

personal contact with the infected individual or article of dress. As a rule, repeated opportunities of contagion appear to be requisite. The modern home, with its roomy apartments and its free ventilation, and modern habits of dress implying frequent changes and great cleanliness, offer no facilities for the spread of such a disease. The enforcement of quarantine has also for some centuries prevented its introduction into England.

No. CXXXIV.—*The Diagnosis of Acromegaly.*

1. A case has been recorded in which a man, aged 37, was affected with swelling of his hands, legs and feet, and with pains in his wrists and knees. His hands and feet attained the size which they had when he came under observation in the course of about three weeks. He was first seen on August 21st, 1888, and he died on October 28th of the same year. The whole duration of his illness was less than six months. At the autopsy, œdema and emphysema of the lungs were found, with, in each, a considerable growth of spindle-celled sarcoma. The liver was nutmeggy.*

Is there any propriety in counting the above case as one of Acromegaly?

2. A man aged 54 died after a six months' illness which had commenced with stiffness in his legs and feet, and had soon been followed by enlargement of both hands and feet. He subsequently had epileptic convulsions, defective memory and delusions. The post mortem showed several cavities of different parts of the brain, a large causating mass in the lower lobe of the right lung, and a nutmeg liver.†

Is there any reason for claiming this case as one of Acromegaly?

3. A girl of nineteen complained of great weakness and swelling of the hands and feet, and of pain in the wrists, knees and ankles; she suffered from palpitation and shortness of breath, with severe pain in the right side. Within three months of the beginning of her symptoms she was confined

* *Illustrated Medical News*, March 2, 1889.

† *British Medical Journal*, March 22, 1890.

to bed with inflammation of the lungs. Her knees, ankles and feet became considerably enlarged, but there was no alteration whatever in the bones of her face or skull.*

What should be the diagnosis of such a case, and, especially, can it be claimed as allied to Acromegaly?

4. A Hindoo lad was the subject of great enlargement of his left foot. His second toe was immensely hypertrophied and the third considerably so; the other toes being all a little thickened. The foot had been enlarged as long as he could remember. There were supposed to be slight changes in the right foot and left hand, but these the patient himself scarcely recognized.

Were these changes those of Acromegaly?

ANSWERS.

1. This case would appear to have been one of general sub-acute rheumatism complicated by old disease of the liver and lungs, and by recent malignant growths in the latter. The whole duration of the case, and especially the rapidity with which the hands and feet had attained their increased dimensions, are quite conclusive against the diagnosis of Pierre Marie's malady.

2. This case seems to be one of hæmorrhagic apoplexy with chronic disease of liver and lungs, and with finally some rheumatic complications. The enlargement of the fingers was probably caused by the pulmonary obstruction, and belongs rather to the class of cases which Marie and Souza-Leite have named pulmonary osteo-arthropathy than to true acromegaly. The whole duration of the case is much too short for the latter malady.

3. This case appears clearly to be one beginning with pleurisy and pneumonia, and complicated with rheumatism. Probably pulmonary obstruction to the return of venous blood had much to do with the enlargement of the fingers, but as there was considerable effusion into the knee joints it is clear that rheumatoid arthritis must be accepted as taking also a large share. As the hands and feet attained their in-

* Transactions of Royal Academy of Medicine of Ireland, vol. ix, p. 64.

crease of size in "a few weeks," it is certain that the case had no real affinity with acromegaly.

4. The non-symmetry and the congenital, or, at any rate, infantile, origin of the changes are conclusive facts against the diagnosis suggested. It was probably an example of congenital pes gigas.

No. CXXXV.—*Niebuhr's Illness.*

Niebuhr, the great Danish historian of Rome, died on Jan. 2, 1831, at the age of 55. He had taken a chill in coming home from a news-room where he had been eagerly studying the trial of the ministers of Charles X. The evening was very cold. His illness was of only a few days duration.

QUESTIONS.

1. How ought the expression "taken a chill" to be translated into medical language?
2. Of what did Niebuhr probably die?
3. Niebuhr had suffered from malaria in his childhood. Is it probable that this had anything to do with his fatal illness?

ANSWERS.

1. Taking a chill implies a reflex disturbance of the nervous system productive of rigor, and attended by congestion and consequent inflammation of some surface or viscus.
2. The cause of death was probably catarrhal pneumonia.
3. The previous occurrence of ague exercises an influence over the patient's nervous system which lasts the rest of the patient's life and gives a special tendency to the occurrence of rigors. It may have increased the injurious influence of the chill. Catarrhal pneumonia is, however, a very common cause of death, quite independently of malaria.

No. CXXXVI.—*On Croup and Diphtheria.*

A CONVERSATION.

Ille. I infer from what you have said that you do not see any real distinction between diphtheria and croup.

Ego. Croup is sporadic diphtheria, and diphtheria is croup become contagious and spreading as an epidemic.

I. Then you think that croup may begin independently of contagion?

E. Most certainly. Sporadic cases of what is called "true croup" begin probably as catarrhal pharyngitis.

I. Then you hold that a malady which takes origin in the causes of ordinary catarrh may become contagious?

E. Undoubtedly. All catarrhs are contagious, and for the matter of that, almost all forms of inflammatory action are productive of elements capable of causing contagion.

I. Diphtheria is now usually placed amongst the specific fevers. Do you doubt the correctness of such position?

E. I do most definitely. I should place it in a group of which erysipelas is the type, and in which a local inflammation precedes and causes the fever. With it I should place phagedæna, cancrum oris, carbuncle and a few others. Eczema when it prevails epidemically, that is when it becomes contagious as recently seen in the London Workhouse Infirmaries, must also be so classed.

I. But the diseases you have named do not usually prevail as epidemics.

E. No, not often, but they do occasionally. We have had terrible epidemics of hospital phagedæna, just as we have recently had of hospital eczema. So also of erysipelas. Its cases are usually single, but when the conditions favour, it may become epidemic. This is the general law of contagious inflammations. They do not usually seem to spread readily, but when once they have become epidemic they may show great virulence.

I. Do we ever witness epidemics of erysipelas from contagion?

E. Yes, and unfortunately medical men are usually the means of spreading them. It is more especially when erysipelas has been transmuted into puerperal fever that we witness its virulence as a contagious malady. Surgeons to large hospitals, however, know more than enough of it in its original type as an inflammation affecting wounds. The present generation of surgeons know little or nothing either of epidemic erysipelas or of epidemic phagedæna, but their predecessors knew them only too well.

I. You believe, then, that erysipelas and hospital phagedæna may originate spontaneously, and may also become contagious?

E. I do. Given the conditions, that is plenty of susceptible persons, and close and continuous intercourse, and they are sure to spread.

I. You speak as if what you term the transmutation of erysipelas into puerperal fever were an acknowledged fact. Is that so?

E. It ought to be. The classic narrative of his own experience by the late Mr. Storrs, of Doncaster, supported as it is unfortunately by much that has since accrued, ought to be held conclusive. Puerperal fever, or puerperal metroperitonitis, is in most instances another name for erysipelatous infection of the placental detachment-wound. During last summer I was made acquainted with the death from "puerperal fever" of a young married woman. I knew also that there had been in the same village a case of fatal erysipelas after a compound fracture of the leg. I found, on cautious inquiry, that the same surgeon was attending these two patients at the same time, and further that the same nurse was transferred from the one case to the other. I have known not a few such coincidences, and during my student life a lamentable and most conclusive piece of experience occurred to myself.

I. But admitting, as all must, that erysipelas may become contagious, are you not assuming what is not probable when you suggest that it ever originates in any other way? Is it ever of spontaneous (so to speak) origin?

E. I take it as exceedingly probable that facial erysipelas may and does often take its origin in exposure to cold wind. Those who have had it once are very prone to have it again. You may say that facial erysipelas is a different disease from erysipelas as we find it attacking wounds. I should be very sorry to expose an operation case to the risk of contagion from the facial disease. Also as regards the traumatic form, it occurs very frequently under conditions which make contagion very improbable. If it always depends upon the introduction of parasitic germs, those germs must be ubiquitous,

and they must also be capable of resting dormant in the organism for long series of years. The patient who has had erysipelas after an operation will very probably have it again after another, even with a ten or twenty years' interval.

I. You do not, then, regard erysipelas as a specific fever?

E. No, indeed. We know nothing of specific fevers of which one attack renders a patient more prone to another. I regard erysipelas as a fairly well specialized type of inflammation which affects lymphatic spaces and which causes fever, but the local process always precedes the fever, not the reverse. Erysipelas observes no definite stages, is of very variable duration and severity, and above all may often be cured most definitely by local means. It is, besides, never symmetrical, but begins locally, and spreads from its place of origin by continuous contagion. It has no analogies with such maladies as measles, smallpox, and syphilis.

I. Do you, then, consider erysipelas as catarrhal?

E. No, not if we are to use our words with precision. I do not believe that a patient would ever get erysipelas of the face from having his feet wet or from exposure of his back to a draught of cold air. It requires some special damage to the part itself, whether from wound, from irritants, or from the direct influence of cold. Catarrhal inflammations are reflex in their mode of production; erysipelatous ones are local.

I. I observed that you mentioned carbuncle with phagedæna and erysipelas. Is it not rather a grouping of dissimilars?

E. I do not think so. A carbuncle is a boil with a tendency to spread at its edges. The spreading is effected by contagion along continuous tissues just as in erysipelas. In truth, the spreading of a carbuncle is by no means wholly dissimilar from that of phlegmonous erysipelas. The same brawny induration and solid œdema attends them both. In both, the amount of disturbance of health and of danger to the patient are in ratio with the extension of the local disease. Both may be cut short at any stage of progress by suitable local measures.

I. To return to our first subject, may I ask if what you

assert as to there being no real difference between croup and diphtheria is generally acknowledged?

E. Professional opinion is in an uncertain state. My impression is that a large majority now make no distinction, and I am sure that those who do so find themselves involved in inextricable difficulties. The two words still occur in most of our statistical list of diseases, and a few cases are still ranked under that of croup. The late Dr. Semple, who translated for the New Sydenham Society the French Memoirs on Diphtheria, became so impressed with the identity, that he used to beg his friends to find him an example of croup. Dr. Afleck, in the "Encyclopædia Britannica," perhaps the latest expression of opinion, holds that they are different, but does not attempt to establish any diagnosis.

I. But is it not still true that cases of inflammation of the larynx and trachea, with the formation of false membrane, are met with in healthy children who have not been exposed to contagion, and from whom no contagion is seen to spread?

E. I have not the least doubt of it. They are what I would call spontaneous or catarrhal cases.

I. Why not call them Croup, in distinction from the epidemic form?

E. I would give them that name, but I would give it also to the other cases. I hold that such cases may become the parents of epidemics.

I. Perhaps you prefer the name croup for both?

E. I do. Brettoneau made, so far as I understand the subject, a serious mistake when he thought that he had discovered that diphtheritis is "not an inflammation but a fever," and named it diphtheria. We must now go back on the old lines. The Germans already use the adjectives croupous, croupal, &c., as applicable to all inflammations of mucous surfaces attended by membranous formation. If we continue the use of the term diphtheria, it must be understood much in the German sense.

I. Still, however, is it not the fact that there is something very peculiar in the debility which attends all true diphtheria, and does not this tendency to exhaustion make the diagnosis between it and other inflammations of the throat?

E. By no means. Men who observe diphtheria only as it is seen in consultation practice or in hospitals, form very exaggerated impressions on this head. Severe cases of diphtheritic throat are undoubtedly attended by great exhaustion, and in some cases the debility may appear to be disproportionate to the local affection. Those who, however, in family practice have opportunities for observing the disease as it occurs in epidemics, will tell us that a great many patients have it very mildly and show no special debility. In many it is simply a matter of a few days' sore throat and nothing more.

I. How do you explain the debility which is so strongly insisted on by all who have described the malady?

E. It is probably in part due to blood poisoning and nerve irritation from the local inflammation, but in perhaps a yet larger part it is the result simply of starvation. A malady which interferes with respiration and almost wholly prevents deglutition, is likely, especially in young subjects, to be rapidly productive of exhaustion.

I. Do you regard the production of membranes as essential to the diagnosis of diphtheria or croup?

E. By no means. The free production of membranes or casts depends upon the proclivities of the individual patient. Age, for instance, may influence it. Old persons but rarely form membranes freely. During epidemics of croup, different cases vary exceedingly as regards the abundance of membranous effusion, and a certain number of even fatal cases are always witnessed in which no membrane whatever is found. Diphtheritis, or pellicular inflammation, although a common and conspicuous feature in most cases of diphtheria or croup, is not an essential. What is known as diphtheritic ophthalmia, for instance, is usually attended by infiltration only, and shows no membrane.

I. If, then, you deny that membranous effusion is pathognomonic, how about the subsequent paralysis? Is that characteristic?

E. There is, I admit, something very difficult to understand in the association of paralysis with diphtheria. I do not, however, in the least believe that the explanation is to be

found in the hypothesis that diphtheria is a fever. As a rule, the occurrence of paralysis after a sore throat may be held to imply that the latter was of the diphtheritic class (including, of course, croup), but it is not conclusive. I have seen paralytic loss of accommodation after other forms of sore throat, and I am inclined to associate it rather with the part affected than with anything specific in the malady. We must remember that paralysis is a rare and quite exceptional occurrence even in diphtheria epidemics.

I. I understand you to deny that there is anything peculiar in the debility which attends diphtheria, to assert that the production of membranes is not essential, and that even the subsequent occurrence of paralysis cannot be held to be pathognomonic. I do not see how the differential diagnosis of diphtheria from other forms of sore throat is to be made.

E. That is precisely the conclusion to which I wished to lead you. We must not attempt arbitrary definitions, and the search for pathognomonic symptoms is one which is very likely to lead us into serious clinical error. The simple fact is that you cannot by a single symptom, nor by any group of symptoms, distinguish croup from diphtheria, or either or both of them from catarrhal sore throat or from hospital sore throat. It is absurd to allow the severity of the case to become an element in its diagnosis. Infantile laryngitis may at any time run on into the most typical croup; in fact the latter is usually preceded by a stage which takes rank under the former name. The difference is one mainly of degree of severity. It is the same with hospital sore throat and the patchy tonsil; you cannot diagnose them from diphtheria, because they are simply its minor forms.

I. Still, I suppose we must make a difference between those cases of diphtheria originating from contagion and those which you would suggest begin from catching cold?

E. There you touch the pith of the argument. Undoubtedly you must. Although I firmly believe that the one may be in a sense the parent of the other, yet they are different. The croup or diphtheria which takes its origin in catarrhs, is more gradual in development than that which results from contagion. When a virus has been bred up to

contagious virulence, it stamps a kind of specificity on the epidemic induced. No two epidemics of contagious croup are exactly alike. Some are much more severe than others. It is also a matter of common observation that the contagion seems to decline in virulence when the epidemic is protracted, and the later cases are less severe than the earlier ones.

I. This, it appears to me, is precisely the law which is so well recognized in reference to the specific fevers, yet you deny that diphtheria is one of them.

E. Quite true; but there is nothing improbable in the suggestion that the law may apply to poisons which still are not absolutely of the same class. No one can doubt that there is a well specialized form of contagion afloat during an epidemic of diphtheria, just as during one of measles; but it is matter for observation to decide whether in the one or other case the contagion may take origin *de novo*. In the case of measles, observation seems to show that it cannot; whilst in the instances of common catarrh, diphtheria, erysipelas, and many others, it seems to indicate that it may.

I. In using such an expression as "origin *de novo*" in connection with "a well specialized form of contagion," are you not perilously near the hated doctrine of spontaneous generation?

E. We must not be frightened by bugbears.

PLATE L.

ACRO-DERMATITIS WITH DISEASE OF THE NAILS.

THE hand of an old man who suffered from acro-dermatitis with chronic disease of his nails. His case is fully described at page 251, Vol. II. He was a man originally in vigorous health, and in childhood had never suffered from chilblains. At the age of 32, that is, forty years before this sketch was taken, he had suffered severely from chilblains. During the last ten years, as an amateur gardener, he had exposed his hands a good deal to cold. A few days of frosty weather were, he said, always sufficient to make his nails brittle, and his finger-ends sore. I have little doubt that both the chronic eczema and the disease of the nails were attributable to the influence of cold upon a patient whose circulation, originally vigorous, was enfeebled by age, and by the previous occurrence of frost-bite. They must rank, therefore, as a form of acro-dermatitis in definite alliance with Raynaud's phenomena.



PLATE LI.

CHILBLAIN-LUPUS OF HANDS.

THIS portrait shows the condition of the hands in the case of a young woman who was the subject of lupus on one cheek, and of ulcerations of the ear. The conditions exhibited may perhaps be ranked as a peculiar form of chilblains. They are met with in association with certain special types of the lupus process, and with feebleness of the circulation. It will be seen that there are numerous pits which have been left by the healing of ulcers, and other little patches where the skin has become white and gangrenous. A portrait showing the condition of the face of the same patient is given in Vol. I., Plate X., and both may be profitably compared with Plates VI. and VII. in Vol. I., which illustrate the case of Philip Holmes; also with Plate VIII. in Vol. I., illustrating lupus erythematosus. These conditions are generally worse in winter and cold weather, but sometimes appear to be almost independent of season.

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